Little Traverse Bay Bands of Odawa Indians
Strategic Prevention Framework
Tribal Incentive Grant No. 1 U79 SP 015611

Significant Prevention Resulting In New Generations (SPRING)

TRIBAL STRATEGIC PLAN

February 15, 2011

LTBB Health Department
LTBB Mental Health/Substance Abuse/Prevention Program

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Acknowledgements

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SPRING Advisory Council

Introduction

The Little Traverse Bay Bands of the Odawa Indians (LTBB) was awarded the Strategic Prevention Framework Tribal Incentive Grant (SPF TIG) grant at the end of July 2009. This project, known locally as SPRING (Significant Prevention Resulting in New Generations) is the first substance abuse prevention effort in which the tribe has participated. This is very important to the tribe, since we have not previously had a substance abuse prevention program and the grant will enable us to address substance abuse prevention in the immediate future, as well as build the capacity and lay the groundwork for future prevention efforts. Unlike the states which have received SPF SIGs (State Incentive Grants), the LTBB tribe previously had no prevention infrastructure and had never created a strategic plan for prevention.

Using data collected by our needs assessment, with the collaboration of our evaluation and epidemiological contractors, and the Tribal Epidemiological Workgroup (TEOW), the SPRING Advisory Council (AC) has selected underage drinking (UAD) as our tribal priority. This strategic plan describes our community and its prevention capacity, the data and process we used to select UAD as our priority, our plans to enhance tribal capacity to reduce UAD, and the mechanism we will use to fund local efforts to reduce UAD and its causal factors.

Tribal Community

LTBB is a federally recognized Indian Tribe reaffirmed by the United States Congress on September 21, 1994 in Public Law 103-324, as amended. The Tribe is governed through the LTBB Constitution which establishes three distinct branches of the Tribal Government: Judicial, Legislative, and Executive. The Executive Branch, led by the elected Tribal Chairman and Tribal Vice Chairman, is authorized to administer the appropriated funds, enforce the Constitution and laws, and implement policies and procedures enacted by the Tribal Council.

Although members of the LTBB tribe are spread throughout the State of Michigan (Figure 1), the LTBB Tribe (recipient of the SPF TIG) covers a 27 county service area (Figure 2). Within the 27 county service area, the Tribe's reservation area encompasses approximately 336 square miles of land within Emmet and Charlevoix Counties. Tribal properties are dispersed throughout this area with the main LTBB Government Center located between Petoskey and Harbor Springs in Emmet County, and a Health Department building and a Human Services building in Petoskey.

As shown in Table 1, the largest concentration of LTBB members (by household) within our service area is located in three counties: Emmet (58.4%), Charlevoix (9.2%), and Cheboygan (7.7%). Due to the unique challenges and diverse setting of LTBB—as well as the fact that Emmet is by far the most populous county in our service area for LTBB members and is the home of our tribal offices—the SPRING project will focus its attention on Emmet County (though we examined data from Charlevoix County, as well). Notably, Charlevoix County is part of LTBB's service area, but is part of the Grand Traverse Band of Ottawa and Chippewa Indians (GTB) service area as well. The county also includes GTB Reservation land within its borders. GTB is a cohort III SPF TIG grantee.

Figure 1. Little Traverse Bay Bands of Odawa Indians Tribal Member Household Geographical Area

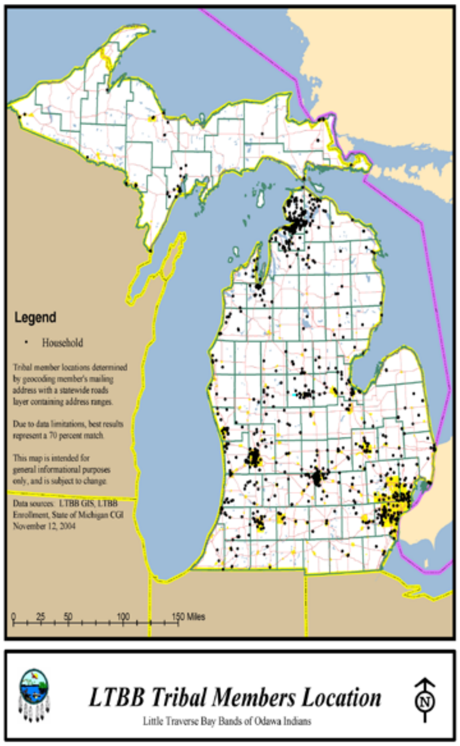


Figure 2. Little Traverse Bay Bands of Odawa Indians Geographical Service Area

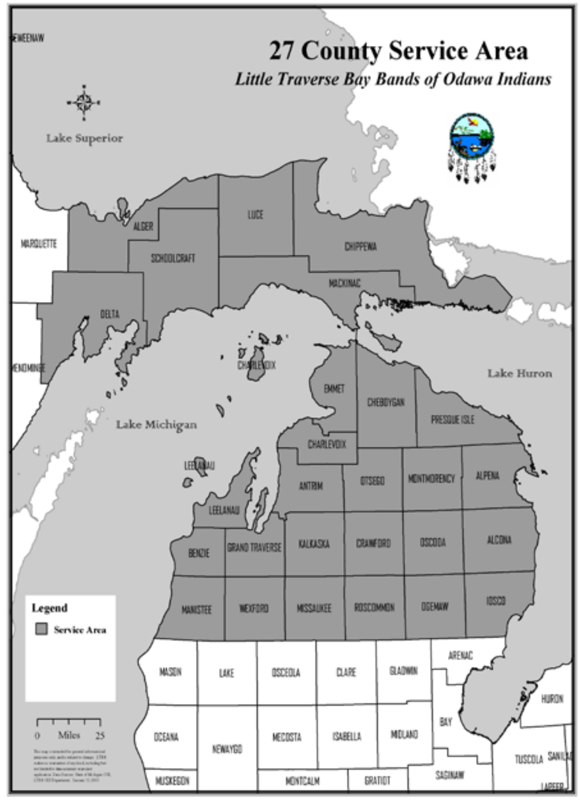


Table 1. Little Traverse Bay Bands of Odawa Indians by County and Household as of March 2010 (27 County Service Area)

County	LTBB Households		County	LTBB Households	
Emmet	58.4%	(n=941)	Oscoda	0.7%	(n=12)
Charlevoix	9.2%	(n=148)	Roscommon	0.5%	(n=8)
Cheboygan	7.7%	(n=124)	Alcona	0.3%	(n=6)
Delta	4.7%	(n=76)	Luce	0.3%	(n=5)
Grand Traverse	3.7%	(n=60)	Ogemaw	0.3%	(n=5)
Antrim	2.5%	(n=40)	Wexford	0.3%	(n=5)
Chippewa	1.7%	(n=28)	Alpena	0.2%	(n=4)
Otsego	1.7%	(n=28)	Presque Isle	0.1%	(n=3)
Leelanau	1.5%	(n=24)	Schoolcraft	0.1%	(n=3)
Mackinac	1.4%	(n=23)	Iosco	0.1%	(n=2)
Manistee	1.1%	(n=18)	Montmorency	0.1%	(n=2)
Benzie	1.1%	(n=17)	Crawford	0.0%	(n=0)
Kalkaska	0.9%	(n=16)	Missaukee	0.0%	(n=0)
Alger	0.7%	(n=12)			

Description of Emmet County

Emmet is a rural county, and according to the 2000 Census, the population was 31,437. Only 35% of the county's residents live in an urban area. The SPF TIG project will focus on the county as a whole, but will also include specific efforts in three of the larger communities: Harbor Springs (population 1,567), Village of Pellston (2,501) and Petoskey (6,080). Overall, 28.7% of the population is under the age of twenty-one and the median age is 29.6. Approximately 95% of county residents are White, four percent are American Indian, and less than one percent identified themselves as Black, Hispanic or Asian. Per capita income was $21,070 or about $1,000 less than the Michigan average. Estimated median income was $40,751 in 2009 or about $5,000 less than the state median income. Eighty-nine percent of the population age 25 years or older had a high school degree, slightly higher than was true for Michigan as a whole (83.4%).

Strategic Prevention Framework

With the assistance of the SPRING Advisory Council (AC), the Tribal Epidemiological Outcome Workgroup (TEOW) and the Evidence-Based Practices Workgroup (EBP), the SPRING staff will implement the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework (SPF). The SPF is a prevention planning process that is data driven and consists of five interactive steps: 1) assessment; 2) capacity building; 3) planning; 4) implementation; and 5) evaluation. Cultural competence and sustainability are woven throughout the fabric of all five steps of the SPF process. The five steps of the SPF are designed to help tribes, states and communities build prevention competencies and the infrastructure necessary to implement and sustain effective prevention policies, practices, and programs. An outline of the five step process of the SPF follows:

1. *Assessment*: collect, analyze, interpret a set of epidemiological data elements and describe substance-related consequences and consumption patterns in an epidemiological profile;

2. *Capacity Building:* provide data and information to key stakeholders to mobilize and enhance Tribe and community resources to address prevention priorities and may assist the Tribe to collect, analyze, and interpret prevention system capacity data;

3. *Planning:* determine key substance-related problems (e.g., specific consequences or substance use patterns, target populations, geographic areas, etc.), and provide these findings to guide Tribal decisions concerning prevention priorities and Tribe allocation of prevention funds;

4. *Implementation:* collaborate with the Tribe and communities to determine strategies that are aligned with and effectively address identified priorities;

5. *Evaluation:* conduct ongoing data collection and analysis to examine changes over time in substance-related problems and patterns of consumption and feed this information into ongoing Tribal decisions about prevention priorities and resource allocation.

Assessing the Problem

Data Challenges

Drug and alcohol use/abuse are, and have historically been major problems for the Native American population. Statewide data on substance abuse rates for Michigan's indigenous people describes a population with early onset of substance use, coupled with multiple risk factors. There are, however, only limited local incidence and prevalence data available. Historically, American Indians have been under-represented in most Michigan surveys, and only data on Black, Hispanic, and White populations have been reported separately.

Recent efforts have tried to address this shortage of data. In 2004, Inter Tribal Council (ITC) of Michigan and the Centers for Disease Control and Prevention (CDC) conducted a multiple tribe intra-state adult American Indian Behavioral Risk Factor Surveillance System survey (BRFSS) and an over-sampling of the Michigan Youth Risk Behavioral Survey (YRBS) for youth in grades 9-12. As a result, the 2005 YRBS and BRFSS reports included a representative sample of AI/AN (American Indian/Alaska Native) population.

The Michigan Profile for Healthy Youth (MiPHY) is a new survey administered by the Michigan Department of Education to 7th, 9th and 11th grade students (both public and private schools) in alternating years with the YRBS. The initial implementation of the survey occurred during the 2007/2008 school year. Participation by school districts or schools within the district is not mandatory, and Emmet County did not participate in the 2008 survey. While there are some data for the first time for Emmet County in the 2010 MiPHY, the number of students who identified as American Indian was relatively small. This may be due in part, because schools with a higher percentage of American Indian students did not participate.

Clearly, data are an extreme challenge for the AI/AN population. Nevertheless, using data from several sources—including two new SPRING surveys described below—the SPRING contracted epidemiologist (Leslie Ballenger, Ph.D.), in conjunction with our TEOW and our evaluator (Pacific Institute for Research and Evaluation, PIRE), collaborated with SPRING staff to conduct a comprehensive assessment of LTBB's prevention needs and capacity in 2010. Data were collected on a wide array of substance abuse indicators, including data about the consumption and consequences of alcohol, tobacco, and illicit drugs, as well as attitudes around the use of those substances. The TEOW and the SPRING staff decided to focus data collection efforts in Emmet County because more than half of the LTBB members in the 27-county service area reside there and, therefore, efforts in Emmet County have the greatest potential for influencing the tribal community. Charlevoix data were included both as a basis of comparison with neighboring communities and because the two counties are part of the same school district.

To fill some of the data gaps we just described, the SPRING staff developed, conducted, and analyzed two[1] tribal level surveys to generate baseline data for the LTBB epidemiological

[1] A third survey was developed for LTBB staff members, but was not included in the reported data because of privacy concerns.

profile. First, SPRING staff administered a survey with questions similar to the MiPHY at North Central Michigan College in the fall of 2010. There were 177 respondents. The age range for participants was 16-72 (36% were below the age of twenty-one), and 23% identified themselves as American Indian. Second, staff also administered a similar survey at the Fall 2010 Traditional Jiingtamok (Pow Wow). There were 123 respondents, ranging in age from 14-88 years old (11% below the age of twenty-one), and 83% self-identified as American Indian. Data from the NCMC and Jiingtamok surveys are presented for all participants and are not limited to individuals under 21 years old, unless otherwise specified.

Data from the needs assessment were compiled in the *SPRING Epidemiological Profile*, which reflects the best consumption and consequence estimates of the LTBB population currently available. The *SPRING Epidemiological Profile* was presented to the SPRING Advisory Council (AC) in October of 2010 and was used as the foundation for decision-making by the AC regarding our priority issue. In the next section, we present the highlights from the SPRING Epidemiological Profile, as they relate directly to our selection of underage drinking as our priority issue. The full *SPRING Epidemiological Profile* can be accessed by contacting Elise Tippett, SPRING Project Coordinator. Table 2 provides a summary of the substance use data that were included in the *SPRING Epidemiological Profile.* The top figure in each cell equals the percentage for American Indian respondents. The bottom figure in each cell (in parentheses) equals the percentage for all respondents.

Table 2. Summary of Substance Use Indicators

	Charlevoix 2008 MiPHY**		2010 MiPHY Middle School (7th grade)		2010 MiPHY High School (9th and 11th grades)		2010 NCMC College survey	2010 Traditional Jiingtamok (Pow Wow)
AI=American Indian (T=total population)	**Middle School AI=9, (T=183)**	**High School AI=6, (T=215)**	**Emmet AI=19 (T=328)**	**Charlevoix AI=13 (T=255)**	**Emmet AI=33 (T=662)**	**Charlevoix AI=14 (T=340)**	**AI=40 (T=177)**	**AI=102 (NonAI=21)**
ALCOHOL								
Alcohol: 30 day use	- (6.1%)	- (29.4%)	0.0% (3.5%)	7.7% (6.3%)	33.3% (25.4%)	45.5% (37.0%)	40.0% (44.1%)	26.8% (28.5%)
Alcohol: binge drinking, past 30 days	- (2.2%)	- (22.3%)	0.0% (1.6%)	0.0% (1.3%)	29.6% (16.0%)	45.5% (17.4%)	38.2% (34.4%)	26.7% (9.5%)
Alcohol: ever used	- (18.9%)	- (60.1%)	11.8% (10.5%)	27.3% (16.2%)	53.6% (46.1%)	72.7% (53.0%)	87.5% (73.4%)	
Alcohol: ever been drunk	- (5.6%)	- (40.4%)	5.6% (1.9%)	15.4% (5.0%)	42.9% (32.2%)	63.6% (40.9%)		
Alcohol: drunk before age 13 (HS), 11 (MS)	- (0.6%)	- (7.1%)	0.0% (0.6%)	0.0% (0.8%)	14.3% (5.1%)	9.1% (5.7%)		
Rode in car w/ person who had been drinking (past 30 days)	- (37.2%)	- (28.4%)	22.2% (31.1%)	46.2% (30.8%)	24.2% (23.3%)	42.9% (25.4%)		
Drove when drinking (past 30 days)	-	- (5.0%)	-	-	9.1% (5.6%)	28.6% (9.1%)	7.5% (14.2%)	8.8% (10.7%)

	Charlevoix 2008 MiPHY**		2010 MiPHY Middle School (7^{th} grade)		2010 MiPHY High School (9^{th} and 11^{th} grades)		2010 NCMC College survey	2010 Traditional Jiingtamok (Pow Wow)
AI=American Indian (T=total population)	Middle School AI=9, (T=183)	High School AI=6, (T=215)	Emmet AI=19 (T=328)	Charlevoix AI=13 (T=255)	Emmet AI=33 (T=662)	Charlevoix AI=14 (T=340)	AI=40 (T=177)	AI=102 (NonAI=21)
TOBACCO								
Cigarettes: smoked in past 30 days	- (2.2%)	- (20.0%)	0.0% (0.9%)	7.7% (2.8%)	33.3% (12.9%)	25.0% (20.3%)	47.5% (29.9%)	23.5% (33.3%)
Cigarettes: smoked 20+ in 30 day use	- (0.6%)	- (6.7%)	0.0% (0.3%)	0.0% (0.4%)	20% (4.4%)	8.3% (5.3%)		
Tobacco: currently use chew or snuff	- (0.6%)	- (2.6%)	0.0% (0.6%)	7.7% (0.8%)	6.7% (6.1%)	16.7% (7.7%)		
OTHER DRUGS								
Marijuana: 30 day use	- (2.2%)	- (13.8%)	5.6% (1.6%)	7.7% (2.4%)	25.0% (12.7%)	27.3% (20.4%)	7.5% (15.8%)	10.8% (14.3%)
Marijuana: ever used	- (2.8%)	- (35.2%)	5.6% (1.9%)	7.7% (2.8%)	31.3% (25.0%)	50.0% (39.3%)	60.0% (47.5%)	22.6%
Cocaine: past 30 day use		- (1.9%)			6.3% (1.2%)	0.0% (2.1%)	0.0% (0.6%)	4.3% (6.3%)
Heroin: past 30 day use		- (0.9%)			0.0% (0.9%)	0.0% (1.2%)	0.0% (0.0%)	0.0% (0.0%)
Barbiturates w/out script: past 30 day use		- (3.8%)			12.5% (2.0%)	9.1% (2.7%)		
Sniffed glue/ inhalants: past 30 day use	- (2.2%)	- (2.8%)	0.0% (2.5%)	7.7% (6.4%)	9.4% (2.1%)	0.0% (4.5%)	0.0% (0.0%)	0.0%
Club drugs: 30 day use		- (4.3%)			12.5% (2.4%)	9.1% (3.9%)		0.0% (0.0%)
Meth: 30 day use		- (2.8%)			0.0% (0.8%)	0.0% (0.9%)	0.0% (0.0%)	0.0% (0.0%)
Prescript drugs w/ out script: 30 day		- (4.2%)			9.7% (4.4%)	0.0% (6.0%)		
Prescription painkiller w/ out script: 30 day		- (11.8%)			12.5% (5.8%)	9.1% (10.0%)		5.9% (33.3%)
No drugs used: 30 days							25% (33.9%)	6.9% (14.3%)

* Cells highlighted in yellow = 25% or greater on the measure.
** A dash indicates number of AI respondents did not reach Michigan Department of Education (MDE) threshold (10 in category) for reporting of data. MiPHY administered by MDE.
A blank cell indicates data were not collected for that item or not available at time of AC review

Alcohol Data

According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), alcohol is the most abused substance in the United States. As previously mentioned in the introduction, data for AI/AN population are limited, if available at all. In efforts to build a strong epidemiological foundation for the LTBB, a brief review of national and state data is included.

Current Alcohol Use – Youth

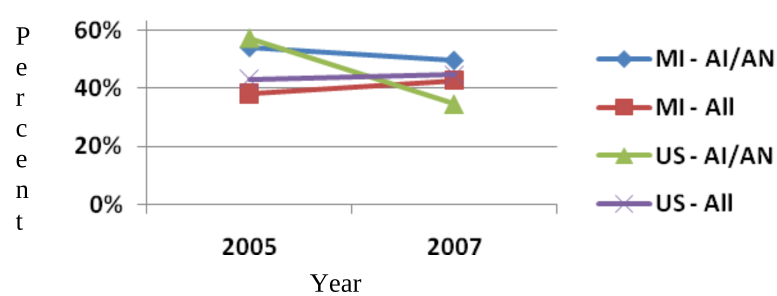
Current Alcohol Use is characterized as alcohol consumption in the past 30-days. As shown in Table 3 and Figure 3, in 2005, over 50% of both Michigan AI/AN youth (54.3%) and US AI/AN youth (57.4%) had at least one drink of alcohol in the past 30-days, and their rates were higher than the rates of all races combined. Notably, from 2005 to 2007, the rates of current alcohol use decreased among AI/AN youth in Michigan and the US (with a substantial decrease among US AI/AN youth), but increased for all races in Michigan and the US. Thus, the Michigan and US AI/AN youth population was moving in the desired direction, and contrary to youth overall.

Table 3. Percent Current Alcohol Consumption – Youth by Location, Race, and Year

	2005 % (n)	2007 % (n)
Michigan - AI/AN	54.3 (139)	49.8 (160)
Michigan - All Races	38.1 (3,112)	42.8 (3,207)
US - AI/AN	57.4 (131)	34.5 (248)
US - All Races	43.3 (13,235)	44.7 (12,669)

Source: YRBSS Youth Online: Comprehensive Results
National Center for Chronic Disease Prevention and Health Promotion
http://apps.nccd.cdc.gov/yrbss/

Figure 3. Percent Youth Current Alcohol Consumption by Location, Race, and Year



Source: Source: YRBSS Youth Online: Comprehensive Results
National Center for Chronic Disease Prevention and Health Promotion
http://apps.nccd.cdc.gov/yrbss/

Binge Alcohol Use - Youth

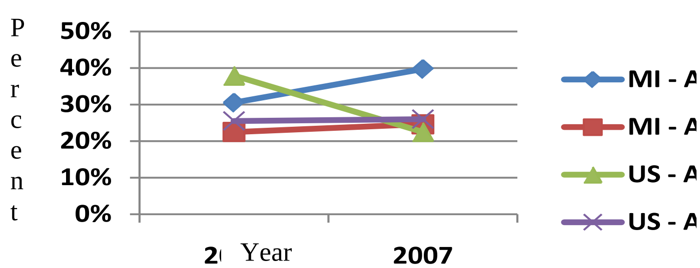
Binge drinking is defined as having five or more drinks in a one setting. As shown in Table 4 and Figure 4, the rates of binge drinking among Michigan AI/AN youth were lower than the rates among US AI/AN youth (30.5% vs. 37.9%, in both 2005 and 2007). The rates of binge drinking among Michigan and US AI/AN youth were higher than they were across all races in Michigan and the US. From 2005 to 2007, there was a slight increase in binge drinking among youth across all races, but not for the AI/AN youth.

Table 4. Percent Binge Alcohol – Youth

	2005 % (n)	2007 % (n)
Michigan - AI/AN	30.5 (141)	39.7 (175)
Michigan - All Races	22.5 (3,174)	24.6 (3,426)
US - AI/AN	37.9 (139)	22.5 (285)
US - All Races	25.5 (13,623)	26.0 (13,588)

Source: YRBSS Youth Online: Comprehensive Results
National Center for Chronic Disease Prevention and Health Promotion
http://apps.nccd.cdc.gov/yrbss/

Figure 4. Percent Binge Alcohol – Youth by Race and Year

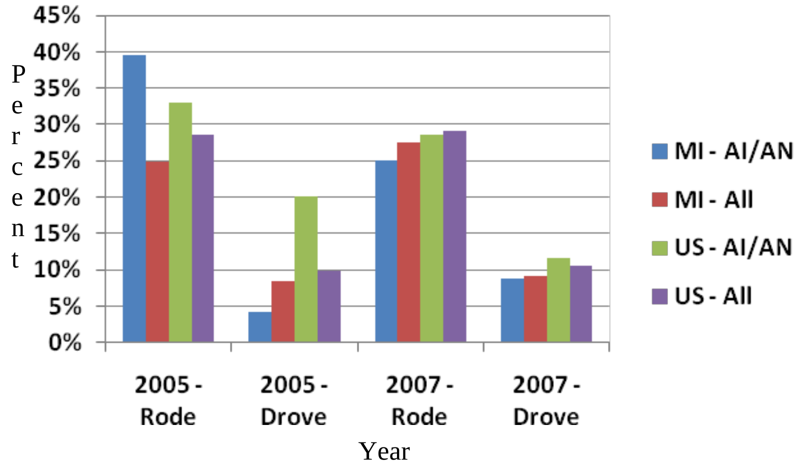


Source: YRBSS Youth Online: Comprehensive Results
National Center for Chronic Disease Prevention and Health Promotion
http://apps.nccd.cdc.gov/yrbss/

Driving or Riding Under the Influence - Youth

Figure 5 shows the percent of youth (MI and US AI/AN, MI and US all races) who reported driving after drinking or riding with someone who had been drinking. In 2005, MI AI/AN youth reported the highest rates of riding with someone who had been drinking (39.6%). Fortunately, the rate decreased to 25% in 2007, when they had the lowest rate. In contrast, only 4.1% of MI AI/AN youth reported driving after drinking in 2005 (the lowest among the groups shown), but that increased to 8.5% in 2007. Notably, US AI/AN youth reported the highest rate of driving after drinking in 2005 (20%), but that decreased substantially in 2007 to 11.7%. The rates of driving after drinking or riding with someone who had been drinking did not change as dramatically for youth across all races.

Figure 5. Percent Driving or Riding While Under the Influence – Youth by Race and Year



Source: YRBSS Youth Online: Comprehensive Results
National Center for Chronic Disease Prevention and Health Promotion
http://apps.nccd.cdc.gov/yrbss/

Table 5. 2009 Percent of Alcohol Use/Consumption by Location and Race

Category	Charlevoix County AI/AN* % (n)	Emmet County AI/AN* % (n)	Charlevoix County* % (n)	Emmet County* % (n)	Compared to State Average^ % (n)	Compared to National Average^ % (n)
Lifetime Use	72.7 (8)	53.6 (15)	53.0 (159)	46.1 (274)	68.8 (3,278)	72.5 (15,953)
Ever Been Drunk	63.6 (7)	42.9 (12)	40.9 (122)	32.2 (191)	68.8 (3,278)	72.5 (15,953)
30-day Use	45.5 (5)	33.3 (9)	27.2 (81)	25.4 (151)	37.0 (3,017)	41.8 (14,864)
Binge Drinking	45.5 (5)	29.6 (8)	17.4 (52)	16.0 (95)	23.2 (3,275)	24.2 (16,009)
Rode with someone who has been drinking	42.9 (6)	24.2 (8)	25.4 (86)	23.3 (154)	27.5 (3,408)	28.3 (16,347)
Drove under the Influence	28.6 (4)	9.1 (3)	9.1 (31)	5.6 (37)	8.4 (3,323)	9.7 (16,121)

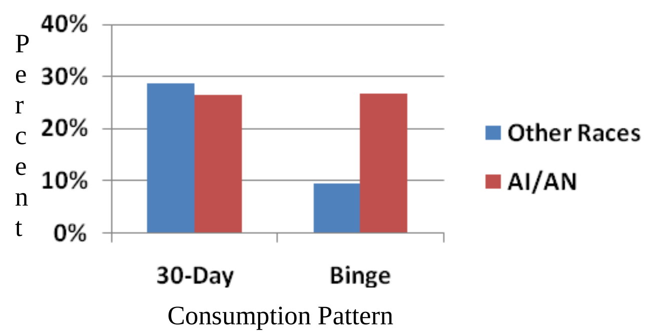
Sources:*2009/2010 MiPHY High School Statistics (Michigan Department of Education)
^2009 YRBSS Youth Online: Comprehensive Results http://apps.nccd.cdc.gov/yrbss/ National Center for Chronic Disease Prevention and Health Promotion
✦YRBSS results for 2009 reflect all races combined; percentage and numbers for AI/AN were to small to calculate and are not presented.

County-level data for Charlevoix and Emmet are available for the 2009-2010 school year from the MiPHY. The results illustrate a higher consumption use for Charlevoix County youth compared to those in Emmet County, regardless of consumption type (lifetime, 30-day, and binge). The percentage of alcohol consumption among Charlevoix AI/AN youth is also higher than all other races combined and the state and national average for AI/AN youth as well (Table 5). The MiPHY revealed that 42.9% of Charlevoix County AI/AN youth reported riding with someone who had been drinking compared to the national average (28.3%). This is in contrast to their Emmet County peers where only 24.2 % reported they had ridden with someone who had been drinking. This is similar to the rates reported across all races within the county, and below the Michigan and national averages (27.5 %, 28.3 %). Also, the Charlevoix AI/AN youth reported a much higher rate of driving after drinking (28.6%) than did Emmet County AI/AN youth (9.1%), Michigan youth (8.4%), and US youth (9.7%). Notably, the rate of driving after drinking among Emmet County AI/AN youth was still higher than all youth across Emmet County (9.1% vs. 5.6%).

Alcohol Use – LTBB NCMC College and Jiingtamok Survey Data

The 2010 LTBB NCMC College Survey (LTBBCS) indicated that 44.1% of respondents reported having at least one drink during the past 30-days and 34.4% reported binge drinking compared, to 49.0% and 26.3%, respectively, in Michigan (BRFSS). Of those who completed the survey who were AI/AN (all ages), 40% reported having consumed alcohol in the past 30-days, and 32.8% reported binge drinking. Table not shown, please refer to the SPRING Epidemiological Profile.

Figure 6. Percent of Alcohol Use –Adult by Race



Source: 2010 LTBB Tribal Event Survey

Results from the 2010 LTBB Jiingtamok survey (Figure 6) showed that current alcohol use among AI/AN (all ages) participants was similar to that of the non-AI/AN participants (26.8% vs. 28.5%). AI/AN participants were more likely, however, to have reported binge drinking (26.7%) than the non-AI/AN participants (9.5%).

Alcohol Summary

Using available data from a variety of state and local sources (including our own SPRING surveys), we estimate the following rates of alcohol use among AI/AN youth, including those in Emmet County: 30% - 52% drink alcohol, 25% - 35% binge drink, 25% ride with a person who has been drinking, and 9% drive after drinking.

Tobacco Data

The 2004 *Surgeon General's Report on Smoking* states that cigarette smoking harms nearly every organ in the body. Cigarette smoking accounts for approximately 440,000 deaths each year in the US, making it the leading cause of preventable death. Cigarette smoking also increases the risk of numerous diseases including heart disease, chronic obstructive pulmonary disease (COPD), acute respiratory illness, stroke, and various cancers. Adolescents who smoke have more respiratory illnesses, and their lung function declines faster than non-smoking adolescents. It is also important to address smokeless tobacco use. Smokeless tobacco includes chewing tobacco and snuff which contain 28 agents known to cause cancer. Long term users of snuff may be 50 times more at risk of contracting cheek and gum cancer than non-users. Using dip eight to ten times a day can expose the body to as much nicotine as smoking 30-40 cigarettes. Nicotine from smokeless tobacco stays in the bloodstream longer than tobacco from a cigarette.

Youth Tobacco Use – Michigan and the U.S.

The 2007 YRBS data indicate that US AI/AN youth were more likely than Michigan AI/AN youth to report initiating smoking before age 13 (26.3% vs. 13.8%); smoking cigarettes during the past 30-days (31.6% vs.18.0%); smoking cigarettes at least 20 of the past 30-days (13.4% vs. 8.1%); smoking at least one cigarette a day for the past 30-days (30.1% vs. 12.7%); and having some form of tobacco use during the past 30 days (34.6% vs. 24.8%).

Youth Tobacco Use – Emmet and Charlevoix Counties

According to the 2009/2010 MiPHY, Charlevoix and Emmet County AI/AN youth were more likely than youth across all races to report tobacco use. Charlevoix County AI/AN youth were more likely than Charlevoix youth across all races to report smoking tobacco in the past 30-days (25% vs. 20.3%), smoking 20 or more cigarettes in the past 30-days (8.3% to 5.3%), and using smokeless tobacco (16.7% vs. 7.7%). The same trend was seen in Emmet County. Emmet County AI/AN youth were more likely than Emmet County youth across all races to report smoking in the past 30-days (33.3% vs. 12.9%), smoking 20 or more cigarettes in the past 30-days (20% to 4.4%), and using smokeless/chew tobacco (6.7% vs. 6.1%).

Adult Tobacco Use –Michigan and Tribe

According to the 2005 BRFSS, the LTBB tribe had higher percent of adults who reported being current smokers when compared to Michigan adults overall (26% vs. 22.1%). The 2010 NCMC College Survey showed almost 30% of respondents had used cigarettes in the last 30 days and over 60% reported having used tobacco at some point in their life. The 2010 Tribal Event Survey reported that 23.5% of AI/AN were current smokers compared to 33.3% of all other races combined.

Tobacco Use Consequences

The consequences of tobacco use can be categorized by the associated mortality (deaths) and morbidity (illness). Although there are virtually no data about the AI/AN population in Michigan, the 2005 MI SPF SIG epidemiological report, *Describing the Burden of Alcohol, Tobacco and Other Drugs on the State of Michigan* provides some consequence data about the State overall. According to that report, Michigan males and females have higher rates of lung cancer and chronic obstructive pulmonary disease (COPD) than the national rates. Since 1993 there has been a steady decrease of lung cancer among men while the number has increased in women. COPD is the fourth leading cause of death in Michigan; in 2003 the rate was 43.8 per 100,000 persons.

Tobacco Summary
Using available data from all state, local and LTBB tribal sources, we estimate that among AI/AN youth, including those in Emmet County: 25% - 33% are recent smokers (30 day use), 8% - 20% smoked 20+ cigarettes (30 day use), and 8% - 17% used smokeless/chew tobacco. For AI/AN adults, the rates were 24% - 48% for past 30 day use and 80% lifetime use.

Illicit Drug Data

The Centers for Disease Control and Prevention (CDC) report that illicit drug use among adolescents has been linked to heavy alcohol and tobacco use, violence, delinquency, and suicide. Illicit drug use is also associated with increased crime, adverse health effects, death, environmental devastation, and lost productivity. The US Department of Justice National Drug Intelligence Center released a report on the Assessment of the National Drug Threat. The report estimated the cost of trafficking and drug abuse annually in the United States to be nearly $215 billion.

Youth Illicit Drug Consumption – Michigan and County
The 2007 YRBS shows AI/AN youth reported higher rates of use for all illicit drugs except for injectable drugs. Marijuana use, in particular, stood out. Relative to Michigan youth across all races, Michigan AI/AN youth reported much higher rates of early initiation as defined as use before the age of 13 years old (25.3% vs. 9.0%) and past 30-day use (35.9% vs. 18.0%) of marijuana. In addition, 45.9% of Michigan AI/AN youth reported being offered, sold or given drugs while on school property, compared to 29.1% of Michigan youth across all races.

Data from the 2010 MiPHY indicate that rates of past-30 day and lifetime marijuana use were higher for AI/AN Charlevoix and Emmet County high school students than for all races combined in their respective counties. In Charlevoix, the rates for AI/AN 30-day use were 27.3% and 50% for life time use, and in Emmet, the rates were 25% and 31.3% respectively. The next highest drugs (30 day use) for AI/AN Emmet County high school students were barbiturates and painkillers without a prescription (each 12.5%), club drugs (12.5%), followed by prescription drugs without a prescription (9.7%), inhalants (9.4%) and cocaine (6.3%). A similar pattern was seen among Charlevoix high school students, although none of the AI/AN students reported using cocaine, inhalants, or prescription drugs without a prescription.

Adult Illicit Drug Consumption – Michigan and NCMC College Survey
NSDUH data indicate that Michigan had higher percentages of marijuana use (past 30-day and past-year), nonmedical drug use, and illicit drug use among those 12 years of age and older for 2004-2006, relative to national rates.

Respondents to the 2010 LTBB NCMC College Survey reported using marijuana more than any other drug at least once in their lifetime—47.5% for all races and 60% for AI/AN. The AI/AN respondents most commonly reported using Vicodin (24.9%), cocaine (22.5%), inhalants (15%), LSD (20.0%), Mushrooms (12.5%), Methamphetamine (7.5%), and heroine (2.5%) at least once in their lifetime without a prescription. Notably however, only 2.5% of AI/AN respondents reported never using any illicit drug over the course of their life time.

Among AI/AN NCMC College Survey respondents, only 7.5% of survey respondents reported using marijuana in past 30-days compared to all other races combined (18.2%). This was followed by Vicodin (5%), Oxycontin (2.5%), morphine (2.5%), and Xanax (2.5%). Twenty-six percent of AI/AN respondents said they had not used any drugs in the past 30 days.

Illicit Drug Use – Tribal Event Survey
In 2010, as previously described, the SPRING staff conducted a paper survey during the Fall Jiingtamok and 123 attendees participated in the survey with 82.9% of the respondents were American Indians or Alaskan Natives. The age of the participants was 14 to 88 years old, with 89.4% being 21 years old or older. Respondents reported that marijuana (22.6%) was the most common illegal drug used in the past 30-days, followed by Vicodin (9.7%), and cocaine (4.8%). Another 3.2% of the respondents reported using Adderall, Oxycontin, or Xanax for non-medical reasons during the past 30-day.

Illicit Drug Use Summary
Across all ages, marijuana was the illicit drug used most frequently, both within a 30-day period and across an individual's life time. (Notably, alcohol use is higher among high school students than illicit drug use). The next rates for illicit drugs were prescription drugs without a prescription. Among high school students, there was also evidence of the use of club drugs in Charlevoix and Emmet Counties and cocaine use in Emmet County. Cocaine use was also reported among respondents in the Jiingtamok survey.

Assessing the Systems (Capacity and Infrastructure)

LTBB has a long and proud history in Northern Michigan, reflected in oral and written histories dating back to well before pre-Columbian times. LTBB entered into treaties with the Federal Government from early contact until well into the 1800's. LTBB was reorganized on September 21, 1994, when President Clinton signed a bill reaffirming the government-to-government relationship with the Little Traverse Bay Bands of Odawa Indians. The LTBB mission statement reads:

> *"Being Odawa is all about Freedom", the freedom to be a part of a people who with integrity and pride, still have and speak our own language. We have the freedom to share in common with all other Odawak the customs, culture and spirituality of our ancestors. The freedom we have today we will bring to the future through unity, education, justice, communication and planning. We will reach out to the next seven generations by holding to cultural values of the seven grandfathers: Wisdom, Love, Respect, Bravery, Honesty, Humility and Truth. We will utilize our tribal assets to provide the necessary tools to become successful, hard-working community members who proudly represent our culture. With these values we will move the tribe forward.*

LTBB has done just that in the sixteen years since reaffirmation. We have had many recent accomplishments, thus demonstrating our strength and vitality as a Sovereign Nation. Currently, there are 211 employees working in 27 different departments of the LTBB Tribal Government Center which was built in 2002. In 2007, LTBB opened the Odawa Casino Resort which is a $140 million facility, encompassing nearly 300,000 square feet. Other accomplishments include bringing health, mental health services, outpatient substance abuse treatment, and dental care to tribal members through the LTBB Health Park. LTBB also owns and runs a local tribal gas station and a fish market. LTBB has two tribal housing projects. The first, WahWasnoodake (Northern Lights) opened in 2000 in Harbor Springs, and the newest one, Mtigwaakiis (small stand of big trees), will open in Charlevoix for residency in February 2011. LTBB is proud to have built the Mtigwaakiis project using "green" products for energy efficiency. LTBB is also exploring other "green" projects such as completing a wind study on tribal property and exploring biodiesel opportunities. The LTBB Planning Department is also helping the broader community by repaving roads within the reservation boundaries of Emmet County. LTBB awards scholarships to encourage higher education for tribal members. The Little Traverse Bay Bands has a Tribal Court, and incorporated a Youth Healing to Wellness Program (youth drug court) in 2000, and recently established a Waabshki-Miigwan Drug Court Program (adult drug court) in 2010.

SPRING Staff

LTBB has not previously had a service unit to specifically address substance abuse prevention, nor has LTBB had prevention funding. The SPF TIG grant has enabled the tribe to hire its first prevention staff, including at least one person with certification as a Michigan substance abuse prevention specialist. The prevention program now has five full-time staff.

SPRING's Project Director is Cheryl Samuels (Ph.D.), manager of the LTBB /Mental Health/Substance Abuse/Prevention Program and an LTBB tribal member (please see Appendix A: Project Staff Resumes and Appendix B: SPRING Flow Chart). Dr. Samuels has extensive experience in the provision of mental health services with native communities, and has a particular interest in the native historical roots of problems we are addressing today in the provision of services. Ms. Elise Tippett, M.S.W., a lifelong resident of Emmet County, began work as the SPRING project coordinator in September of 2009. Prior to that, she worked as a LTBB tribal social worker (beginning in 2006); a position that gave her extensive experience with the tribe. Ms. Susan Pulaski, M.A., is the prevention health educator for the SPRING project and previously worked as the Lead Prevention Specialist for the Health Department of Northwest Michigan. She was responsible for the implementation of curricula such as Project Northland and Project Alert, and is certified by the State of Michigan as a Prevention Consultant. Ms. Pulaski also served as a member of a local seven county coalition that went through the SPF process as part of Michigan's SPF SIG project (cohort I). The effort (still going strong) focused on reducing prescription abuse/misuse. Ms. Tippett (Pellston/Harbor Springs) and Ms. Pulaski (Petoskey/Pellston) are both very involved in their local communities and with local educational and social organizations. In addition, Dr. Samuels (Harbor Springs) is very involved at the national level (representing the needs of 100,000 AI's in the national advisory group for national mental health funding initiatives). At the state level, Dr. Samuels is a member of the Behavioral Health Network, a coalition of the 12 Tribes and one urban Indian Center in Michigan. On the local level, Dr. Samuels is a member of SAFE in Northern Michigan and the Human Services Coordinating Body as well as its workgroup for suicide prevention. All of the staff have strong connections to local communities and to Emmet County as a whole. This in turn should facilitate the enhancement of existing partnerships and the building of new relationships to aid in the overall project.

Yvonne Goudreau, B.S. (Human Services) and Jeannie Norris, B.S.W. serve as the community outreach workers for the project. Ms. Goudreau has sixty-four credit hours (in addition to her Bachelor's Degree) in substance abuse prevention and treatment. She was also employed as a Substance Abuse Counselor and Prevention Worker for the Sault Ste. Marie Tribe of Chippewa Indians, of which she is a member, and has previously taught life skills classes. Ronda Ellis serves as the administrative staff for the project, and she along with Ms. Norris are LTBB tribal members with extensive knowledge of the tribe and the broader community. Ms. Ellis also provides valuable insight to the project from the perspective of a LTBB parent.

Given the newness of the prevention effort and the staff, as well as the need to build the prevention infrastructure from the ground up, there is a great need for training among the prevention staff, SPF TIG workgroups, other tribal departments, and community members. Trainings to-date have included, but not been limited to, the following: the five SPF steps; Introduction to Tribal Epidemiology; community readiness and developing community leadership; community organizing; evaluation; strengthening capacity; Evidence-Based Practices, Policies and Strategies; and Environmental Strategies. Additional training needs include substance abuse prevention in general and the SPF process in particular, as well as how to create a sustainable prevention infrastructure (please see Appendix C for a timeline that includes plans for training). SPRING staff will coordinate training in conjunction with their

Project Officer, the Central Regional Expert Team (C-RET), Dr. Ballenger (our epidemiologist), and PIRE.

The Advisory Council has been very invested in the SPF process. Not only do they actively participate in SPRING AC meetings, but they have often voluntarily extended the meetings to get more work done as they went through the initial SPF steps. Members have also volunteered (on their own initiative) to serve as AC representatives with the SAFE Coalition in Northern Michigan (mentioned below), and to facilitate other community partnerships. The AC approved final operating guidelines at their December 2010 meeting. (Please see Appendix D for more details.)

The TEOW has been meeting regularly and will add new members once the SPRING Strategic Plan is approved. The TEOW has developed a charter and operating guidelines for its on-going work. (Please see Appendix E: Tribal Epidemiological Outcomes Workgroup for more details.)

Community Organizations/Partners

The SPRING staff work under the auspices of the LTBB Health Department and within the Mental Health/Substance Abuse/Prevention Program. Elise Tippett, M.S.W. reports directly to Dr. Cheryl Samuels, Project Director. Dr. Cheryl Samuels reports directly to the director of the Health Department. The director of the Health Department reports directly to the Tribal Administrator. The SPRING staff also work with other LTBB governmental departments, such as the Gijigowi Bipskaabiimi Department (Education, Archives, Records), Human Services, Law Enforcement, Tribal Court, and Youth Services. The Advisory Council includes representatives of many of these departments, and a high level of investment is evident based on meeting participation and voluntary assistance outside of the meetings.

SPRING Project Director and staff are members of the Substance Abuse Free Environment of Northern MI (SAFE), a regional coalition covering Charlevoix and Emmet counties. SAFE is a workgroup of the Human Service Coordinating Body of Charlevoix and Emmet Counties. The coalition envisions a community where youth do not use alcohol, tobacco or other drugs, and seeks to accomplish this mission through partnerships with families, schools, and communities. The current tribal administrator previously served as a chair for the coalition. There is an adult and a youth version of SAFE and tribal youth have been involved with the latter group.

There has been some discussion with SAFE about the coordination of prevention efforts where there is a common interest, and the tribal administrator will offer an MOU for discussion at their next meeting. At the January 2011 SPRING Advisory Council meeting, members decided that there should be active AC representation on the SAFE coalition. In addition, SAFE has previously had discussions about establishing a group in Pellston and several members of the AC volunteered to join such a group. They also suggested a *meet and greet* with the AC and SAFE coalition members in an effort to build a good working relationship. Local agencies are represented on the SAFE coalition, so collaboration would provide LTBB with needed access to local agencies and community leaders involved in substance abuse prevention. SAFE is currently focusing its efforts on addressing low perceived risk of legal consequences or getting caught for alcohol misuse among adults and youth during the current school year.

As mentioned earlier, one of the SPRING staff served on a regional coalition focused on the misuse/abuse of prescription drugs (funded under the MI SPF SIG) and has a continuing relationship with Northern Michigan Substance Abuse Services (NMSAS), the coordinating agency responsible for substance abuse services and prevention for an area that largely overlaps with tribal territory. The NMSAS prevention coordinator has been approached about the SPRING project and has expressed interest in serving on the TEOW.

Other entities which are viewed as potential partners are the Health Department of Northwest Michigan which provides substance abuse prevention curriculum in the schools (Project Northland and Project Alert); Community Alternatives to Substance Abuse (CASA--a community group in Harbor Springs with a focus on substance abuse issues in their schools); the Petoskey YMCA; local, county and state police; the schools (particularly a few principals, coaches, and Title VII staff); store owners; and other human services agencies. As part of the assessment phase (and discussed in more detail below), SPRING staff conducted 48 key stakeholder interviews with individuals from the tribe and from other sectors in their communities. During this process, a number of representatives from the above-named organizations indicated a strong interest in working with the tribe on the UAD priority issue.

In addition, there are a number of opportunities for partnerships and the leveraging of resources in Emmet County. The Pellston schools have a 21st Century Grant which provides after school programming for students experiencing academic difficulties in grades K-8. The Petoskey-Harbor Springs Area Community Foundation and its Youth Advisory subcommittee are very interested in funding initiatives focused on issues relevant to local children and teens. The Human Services Coordinating Body of Emmet and Charlevoix Counties, a state-endorsed community collaborative body, works to facilitate inter-agency cooperation, coordination and collaboration for the improvement of human services. The tribal administrator, SPRING project director, and a SPRING staff member participate with this group. Recently, a health clinic was started in Pellston High School and it provides free services to youth in the community. The SPRING staff believes there is potential for partnering with the clinic on substance abuse prevention.

At the state level, some of the SPRING staff attended the last two Michigan SPF SIG state-wide meetings and participated in meetings of Michigan’s SEW and Evidence-based practices workgroups. One member of the Michigan Bureau of Substance Abuse and Addiction Services serves on the SPRING Advisory Council and many of the state and regional staff have offered to share their knowledge and experience with all aspects of the SPF process to the SPRING staff.

To date, training and technical assistance (TA) have been provided to the SPRING staff by Community Anti-Drug Coalitions of America (CADCA) and C-RET. Training has included SPF steps, evidence-based strategies, building capacity, leadership development, engaging the community and partners, and cultural competency. The C-RET has also provided consultation with Stevie Burden to the staff on strategies relevant for tribal communities and capacity building. Because there were no prevention staff in place prior to the awarding of the SPF TIG grant, all of the training has occurred since the grant was received. Staff have, in turn, provided training to the AC, TEOW, and EBP workgroups on the SPF process. There is an on-going need for training for the staff, the AC, and the TEOW, particularly in the areas of community capacity development, evidence-based and environmental strategies, SPF implementation and evaluation, and community organizing skills (Please see timeline in Appendix C). This will be particularly important as we move into the strategy planning and the implementation phase in the three service areas.

A significant gap exists in the availability and collection of data specific to the overall American Indian population and to LTBB tribe. The 2010 MiPHY was the first year that data were available for the Indian youth in the schools. Even so, the numbers were fairly small, thus limiting the reliability and validity of the data. Relationships with the schools will need to be developed and utilized to increase overall participation in the bi-annual survey, and specifically that of Indian youth. As previously mentioned, we made progress in data collection with our surveys of college students and the fall Jiingtamok participants. There are plans to continue these surveys and to add a survey at the summer LTBB Homecoming Pow Wow. The staff will need additional training on the creation and use of databases for entering and analyzing the survey data. They are currently using Survey Monkey to enter the data, but have purchased software that will better meet their needs. There are no systems in place for prevention program monitoring, since no programs have yet been implemented. A system will need to be developed as we move forward. We will collaborate with PIRE to identify our best options.

The capacity and readiness of the local communities in Emmet County to implement the SPF is mixed. Petoskey has more agency and community resources and a history of collaboration on prevention efforts. This is less true for the Harbor Springs and Pellston communities. For example, although the Human Services Collaborating Body and the SAFE cover all of Emmet County, most of the participating agencies are located in Petoskey. There is one hospital for the county and it is located in Petoskey. Residents of Pellston often drive to the next county, Cheboygan, for medical services because it is closer than Petoskey. SAFE has had a number of initiatives around prom night and graduation, but much of the community participation is located in Petoskey. In addition, there is no public transportation in the county. However, the lack of transportation presents a greater barrier, particularly for youth, in Harbor Springs and Pellston due to their more rural nature. To be successful in these communities, solutions to the transportation issue will have to be developed. For these reasons, the AC decided to begin implementation of the SPF in Petoskey, while at the same time developing capacity in all three communities. The effort in all three communities will need to include the development of additional data sources, such as that from local police, the courts, and the hospital. In the latter case, a state source has been contacted who may be able to facilitate the provision of emergency room admission data for the region. The current plan is to begin our work in Petoskey as soon as the strategic plan is approved and then to phase-in the other two communities during the next 12 – 16 months (adding each community in 6-8 month intervals).

Criteria and Rationale for SPF TIG Priorities

Prioritization Process

In October of 2010, the TEOW reviewed all of the substance abuse data gathered from their Jiingtamok and NCMC college surveys, as well as from all other existing data sources. Where available, data for the American Indian population were compared to the broader community and to the State. Comparisons were also made within age categories. There were no consequence data available specifically for the American Indian population in the region. The TEOW will be working on developing the partnerships to collect these data in the future. Data from the Charlevoix County Schools MiPHY were presented for comparison purposes only, as the AC had already determined that SPRING should target Emmet County because most of the LTBB population resides there. On the whole, trend data were not available for the tribe, and where they were available, the number of respondents on which the indicators were based was very small. For this reason, the main consideration was availability of prevalence data and specifically data for American Indians. Once this process was completed, the TEOW and the epidemiologist presented all the data to the Advisory Council on October 25, 2010.

After the Advisory Council reviewed the data, they met in small groups and were asked by the TEOW to individually prioritize their top indicators and then come to a group consensus on their top three choices. Prioritization of indicators was based on four criteria: (1) data availability, and size/magnitude of the issue, relative to the other indicators within and across the various substances, (2) availability of resources to address the issue, (3) the readiness and political will of the community to address the issue, and (4) the likelihood that measurable change could take place during the life of the grant (preventability/changeability). Each criterion was ranked on a 5-point scale. The TEOW chose this particular approach because they felt it would lend itself to a broad discussion of the quantitative prevalence indicators, as well as tap into AC knowledge of local capacity and willingness to address the issues.

The top priority issues that emerged from the small groups were underage drinking, binge-drinking across all ages, tobacco use, and misuse/abuse of prescription drugs. Following the small groups, a large group discussion was held to discuss the differences in rankings. The large group decided to eliminate prescription drug misuse/abuse as an issue because they were not aware of any evidence-based strategies to address the problem. The priority scores for the remaining three indicators are shown in Table 6.

Table 6. Advisory Council Average Assessment of Top Three Substance Abuse Issues Identified

Issue	Preventability/ Changeability	Readiness/ Political Will	Capacity/ resources	Overall average
ALCOHOL				
Underage drinking	3.29	**3.38**	**3.12**	**3.26**
Binge drinking - all ages	2.63	2.85	2.77	2.75
TOBACCO				
Underage tobacco use	**3.55**	3.26	2.84	3.22

Description of SPF TIG priorities

By consensus, the AC chose the reduction of underage drinking (30 day use) among middle school, high school and college students as their priority issue. This issue had the highest overall priority score, and was identified as a top issue by all the small groups. According to the 2010 MiPHY data, 30 day use jumps from 0% among Emmet County American Indian middle school students to 33% among high school students. Although the rate is lower for American Indian (AI) students than for the population as a whole at the middle school level, the reverse is true at the high school level. There was discussion about whether to choose one or two priority issues, but the decision was made to only focus on one priority because this grant is a first-time effort in the prevention arena for the tribe and it was thought that two priorities might dilute their efforts.

The AC agreed with the SPRING staff's recommendation to focus the project's efforts on Emmet County because it has by far the highest percentage of LTBB members. There was a concern that staff resources would be stretched too much if more than one county was included, given the traveling distances and limited community resources. Thus, the AC considers Emmet County to be their targeted community. Within Emmet County, the largest service areas are Harbor Springs, Pellston, and Petoskey, and the AC decided to gather more data from these service areas for the next phase of identifying the factors that contribute to UAD in Emmet County (described in the next section). Charlevoix County *may* be considered for a later introduction to the SPF process, but whether this possibility is realistic during the current SPF TIG grant period is not yet clear. The decision will be reviewed by the AC after actual implementation in Emmet County communities is well underway.

A few members of the Advisory Council were not present at this meeting due to other responsibilities. The staff followed up with them to review the data and to obtain their feedback on the selected priority and county. AC members who had not been present at the meeting all agreed with the identified priority and county.

Identifying Contributing Factors

Once the SPRING AC selected UAD as the priority issue for the project, SPRING staff turned their attention to identifying the community-level factors that seem to contribute most to underage drinking. Their task was first to determine which broad categories of Intervening Variables (IVs) are most responsible for UAD. Using an Intervening Variable model typical of the SPF SIG in other states and jurisdictions, SPRING focused on seven potential IVs—retail access, social access, law enforcement and adjudication, pricing, promotion, perceptions of risk of harm, and social and community norms. Within those broad categories of IVs, SPRING staff were then to assist with data collection to determine which specific factors appear to contribute most (referred to as contributing factors or CFs) to UAD in their communities. Notably, there were very limited data (if any) available regarding law enforcement and adjudication, pricing, and promotion. The TEOW has plans to address this issue during the course of the project.

To help identify the IVs and CFs for the SPRING project, Dr. Ballenger and PIRE reviewed MiPHY, the NCMC College Survey, and the Traditional Jiingtamok data to examine variables that were associated with underage drinking. In addition, SPRING staff conducted 48 key stakeholder interviews in Harbor Springs, Pellston, and Petoskey, as well as three focus groups with high school youth from Emmet County communities during the fall of 2010. Similar questions were used for both the key stakeholder interviews and the focus groups (Please see Appendix F for a list of questions).

Key stakeholders represented LTBB tribal administration and department leaders, LTBB elders, Charlevoix/Emmet Intermediate School District, Emmet County Courts, hospitals, Veterans Affairs, North Central Michigan College, parents, stores, restaurant, Petoskey YMCA, Title VII workers, Emmet County Sheriff's Department, coaches, and substance abuse treatment providers.

There were a total of sixteen high school students between the ages of 14 and 18 who participated in the focus groups. The focus groups conducted at Harbor Springs High School consisted of 6 students (4 males and 2 females) and 5 students at Pellston High School (1 male and 4 females). All students were identified as tribal members by either the counselor or the Title VII worker at the schools. Approximately four percent of the students attending Harbor Springs High School and thirteen percent of students at Pellston High School are tribal members. Five students (4 males and 1 female) participated in the focus group at Lakeview Academy. Although Lakeview Academy is in Petoskey, students attending this high school are court-ordered and come from all areas of Emmet County. The Lakeview focus group participants identified themselves as LTBB (2), White/Caucasian (2) and African American/Black (1). Currently, 24% of the students attending Lakeview Academy are American Indian.

At the November 23, 2010 meeting, the AC met to review all the IV/CF data. Analyses from the interviews and focus groups were only available for the Pellston area, so no final decisions were made about specific IVs and CFs at this meeting. Participants ranked IVs based on the same criteria used for choosing the priority issue (preventability/changeability, readiness/political will and resources/capacity). Again, a small group/large group process was utilized to discuss the rankings. A final decision about the IVs and CFs was made by the AC at the December 14, 2010 meeting, at which time relevant data from Emmet County and the three communities were reviewed (including MiPHY data). The goal was to select IVs and CFs that had the highest prevalence rates and were common across all three locales, while also taking the other criteria into account.

Table 7 presents survey data for middle and high school youth in Emmet County who participated in the MiPHY, and data for respondents under the age of 21 who participated in the college survey. (We included data from Charlevoix County for comparison purposes only.) The top figure in each cell equals the percentage for American Indian respondents. The bottom figure in each cell (in parentheses) equals the percentage for all respondents.

Table 7. MiPHY and College Survey Results Related to Intervening Variables and Contributing Factors

	2010 MiPHY MS*		**2010 MiPHY HS***		**NCMC College Survey**
AI=American Indian T=Total population	Emmet AI=19 (T=328)	Charlevoix AI=13 (T=255)	Emmet AI=33 (T=662)	Charlevoix AI=14 (T=340)	(only younger than 21) AI=8 (T=64)
SOCIAL ACCESS (IV)					
if drank, took it from a family member: past 30 days	- (45.5%)	- (35.7%)	- (15.2%)	- (16.5%)	12.5% (14.3%)
if drank, got it from home/garage					100% (100%)
if drank, someone else usually gave it to them: past 30 days	- (27.3%)	- (28.6%)	- (31.8%)	- (27.8%)	
if drank, got it from friends: past 30 days					50.0% (42.9%)
SOCIAL NORMS (IV)					
Students whose friends would say their alcohol use is <u>not</u> wrong or very wrong					50.0% (64.3%)
Students who said alcohol use by peers is <u>not</u> wrong or very wrong	10.5% (7.2%)	15.4% (12.2%)	54.5% (38.1%)	46.2% (41.8%)	
Students who reported their parents felt regular alcohol use to be wrong or very wrong	100% (95.6%)	100% (94.0%)	69.7% (84.9%)	69.2% (82.3%)	
Students who reported they thought their friends had been drunk recently	26.3% (11.5%)	15.4% (17.1%)	72.7% (68.3%)	75.0% (74.0%)	
PERCEPTION OF RISK (IV)					
Students who reported regular alcohol use <u>not</u> a moderate or great risk	21.1% (23.8%)	38.5% (27.6%)	27.3% (32.9%)	53.8% (36.8%)	

	2010 MiPHY MS*		2010 MiPHY HS*		NCMC College Survey
AI=American Indian T=Total population	Emmet AI=19 (T=328)	Charlevoix AI=13 (T=255)	Emmet AI=33 (T=662)	Charlevoix AI=14 (T=340)	(only younger than 21) AI=8 (T=64)
Students who reported binge drinking not a moderate or great risk					25.0% (35.7%)
RETAIL ACCESS (IV)					
if drank, bought at a store or gas station: past 30 days	- (0.0%)	- (0.0%)	- (3.3%)	- (6.0%)	
Past 30 days: bought at a gas station					12.5% (1.6%)
Past 30 days: bought at a liquor store					12.5% (8.1%)
If drank, bought at a restaurant, bar, or club: past 30 days	- (0.0%)	- (0.0%)	- (0.7%)	- (2.0%)	0.0% (1.6%)
If drank, bought at a public event (concert, sporting event, etc.): past 30 days	- (0.0%)	- (0.0%)	- (0.7%)	- (2.0%)	0.0% (3.2%)
If drank, gave someone else the $ to buy it for them: past 30 days	- (0.0%)	- (7.1%)	- (27.2%)	- (27.8%)	

**A dash indicates numbers of AI respondents did not reach Michigan Department of Education MDE) threshold (10 in category) for reporting of data. MiPHY administered by MDE.
Blank cells indicate that data were not collected on this item.

Although we have American Indian data for the social norms and perception of risk in the 2010 MiPHY data, their responses on the social access and retail access variables did not reach sufficient levels to report their specific data. We do, however, have data for the overall student population. Among middle school students, indicators for social access, social norms, and perception of risk appeared to be particularly troubling. For Emmet County almost half of the middle school respondents who had a drink in the past 30 days took it from a family member; a rate three times that found among high school students. A little over 25% of the middle school students said they obtained alcohol through friends, about five percentage points lower than that found among high school students. On the other hand, about a quarter of high school students gave someone else the money to buy alcohol for them, compared to zero percent of middle school students. Thus, retail access for these two age groups seems to be less of an issue than social access. Direct retail access was a greater issue for college students under 21 years old, than was true for middle and high school students; however, it was still less problematic than social access.

MiPHY data also indicate that the younger the student, the more likely they were to perceive that use of alcohol by peers was wrong, and the perception of risk significantly decreased with age. In

Emmet County, 92.8% of the 7th graders thought that peer use of alcohol was wrong, while only the 71.7% of the 9th graders and 49.7% of the 11th graders felt the same. Similar results were found regarding students' perceptions about their ability to obtain alcohol—the younger the student the more difficult for them to get alcohol. Lastly, about a quarter of American Indian middle and high school students in Emmet County did not think there was a risk from regular alcohol use. Particularly troubling was the fact that an equal percentage of tribal college youth under the age of 21 did not think there was a risk from binge drinking (although this figure was lower than that for the total population).

Table 8 provides the data from the youth focus groups and key informant interviews. The table shows the high number of respondents who identified issues related to social access, family and community norms, and low perceptions of risk as factors that contribute to underage drinking in their communities. The table also indicates that, in most cases, these factors are seen to affect the broader community as much as the LTBB community.

Table 8. Interview and Focus Group Results Related to Intervening Variables and Contributing Factors

	Key Stakeholder Interviews				**Youth Focus Groups**		
For the focus groups, it was recorded only whether an issue was mentioned, not the number of mentions	**Pellston (8)**	**Harbor Springs (9)**	**Petoskey (8)**	**General (23)**	**Lakeview (5)**	**Pellston (5)**	**Harbor Springs (6)**
SOCIAL ACCESS (IV)							
(CF) Parents provide for use in their home	4B,4T	3B,2T	14B, 15T	3B, 3T	B,T		
(CF) Youth take from home without parental knowledge	4B,4T	4B,3T	12B,12T	3B, 3T	B,T		
(CF) Older siblings provide alcohol	B,T	3B,4T	15B,15T	5B,6T	B,T	B,T	B,T
FAMILY AND COMMUNITY NORMS (IV)							
(CF) Favorable parental attitudes toward alcohol and involvement in alcohol	3B, 4T	2B,2T	7B,7T	6B,6T	B,T	B,T	
(CF) High rates of alcohol use among family and community (e.g., at community events, sport activities, and graduation)	5B,5T	1B,1T		10B,10T			
(CF) Peer pressure to use alcohol	3B,3T	4B,4T	9B,8T	20B,19T	B,T		B,T
(CF) Poor role modeling by parents and community regarding alcohol	3B,4T	3B,2T	5B,3T	13B,13T		B,T	B,T
PERCEPTION OF RISK (IV)							
(CF) Lack of knowledge about substance abuse (Physical & Legal)	2B,2T		1B,1T	3B,3T			
RETAIL ACCESS (I.V.)							
(CF) Grocery Store/Party Store sell to minors				4B,4T			

B=Mentioned in relation to the broader community
T=Mentioned in relation to the tribal community
Numbers may add up to more than # of respondents if mentioned in different contexts

Based on the data and prioritization process previously described, the AC chose to focus on three intervening variables: social access, social norms, and low perception of risk associated with alcohol usage. Furthermore, the AC honed in on the specific contributing factors listed below to address within each of the IVs. Unless specified, the contributing factors listed below are relevant for middle school, high school and college students (under the age of 21). (See Figure 7 for the SPRING logic model, which shows the connections between UAD, the IVs, and the CFs.) Once the SPRING project moves to the community level, communities may opt to address all of the IVs and CFs below, or only those which local evidence suggests are more relevant for their community.

Social Access

- Youth obtain alcohol from their families
- Youth obtain alcohol from home (with or without parental knowledge)
- Youth obtain alcohol from their friends.

Social Norms

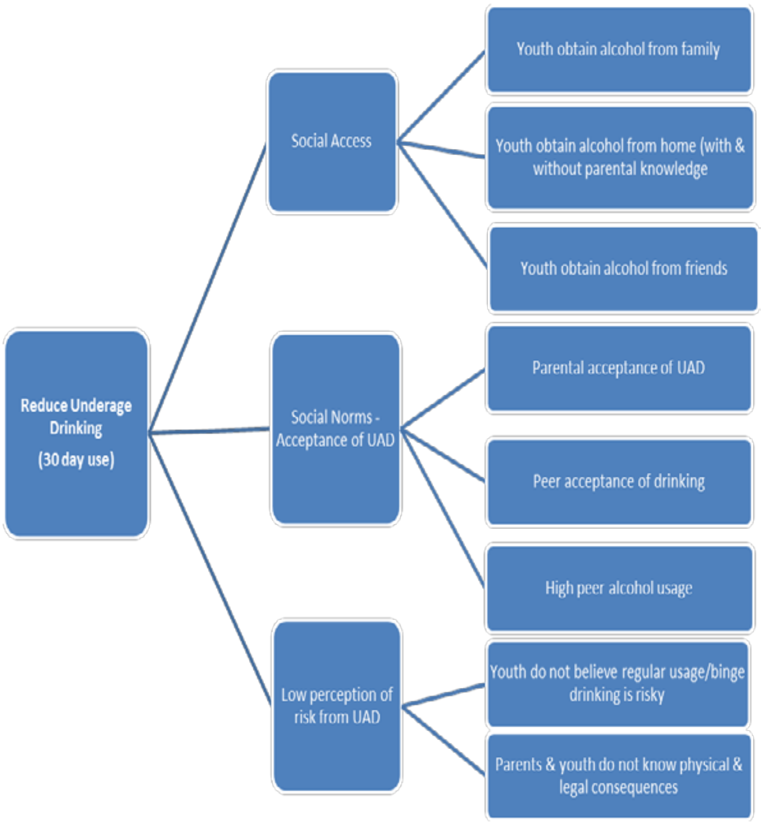
- High parental acceptance of UAD (High school age)
- High peer acceptance of drinking (High school and college ages)
- High use of alcohol among peers

Low Perceptions of the Risk Associated with Alcohol

- Youth do not believe that regular alcohol use or binge drinking is risky
- Parents and youth do not know the physical and legal consequences of UAD.

Figure 7. LTBB Underage Drinking Logic Model

Priority Issue | **Intervening Variables** | **Contributing Factors** | **Strategies**



To be determined by communities

Capacity Building

Areas Needing Strengthening and Tribal Activities

As mentioned previously, substance abuse prevention is a brand new initiative for LTBB, both as a governmental entity and as a community. While there are many strengths the tribe can tap into within its structure and the broader community, there are also many challenges that will need to be addressed. One of the biggest gaps are the lack of a prevention system that will support prevention efforts, as well as an on-going data collection system for LTBB-specific consequence, consumption and intervening variable level data. Table 9 includes additional gaps and solutions that have been identified by the staff and members of the AC.

Table 9. Capacity Gaps and Solutions

Identified Capacity Gap	Method to Address Gap
Communities (Harbor Springs, Pellston, and Petoskey) have a limited understanding of prevention and/or its importance.	Provide training on prevention and the SPF process for all three communities with a focus on both the tribal community and potential leaders for coalitions/taskforces.
Two communities lack a substance abuse coalition or taskforce.	Provide assistance with the development of a substance abuse prevention coalition or taskforce in Harbor Springs and Pellston.
Staff have identified the need for additional training in the SPF steps (more in-depth), community organizing, evidence-based practices, environmental strategies, setting up and strengthening coalitions or taskforces, recruitment and retention of committee/taskforce members and running effective meetings.	A timeline for training has been developed with the CAPT C-RET and will be updated as SPRING moves further along with the SPF process. Other training will be explored as well.
When hiring for prevention positions, the applicant pool often doesn't have the prevention training necessary.	Work with other groups, such as NMSAS (regional SA coordinating agency) to bring in general prevention training for county. Possibly work with community college to add prevention work force curricula.
The AC, staff, workgroups, and communities need on-going training on SPF steps and evidence-based programs, policies, practices, and strategies.	Develop an annual calendar of training to be provided at AC meetings, as well as additional opportunities for staff, workgroups, and the communities.
There is not an orientation in place for new committee members (AC and workgroups) and staff to the SPF process and to roles and expectations.	Develop an orientation (including an orientation manual) for new members of the AC, workgroups and staff as needed.
The TEOW needs more in-depth training on both assessment and evaluation.	Collaborate with the CAPT C-RET and PIRE to provide training for the TEOW on assessment and evaluation, data collection and systems for on-going assessment and ways to make data available to those who need it.
We have informally identified five or six levels of enculturation in our service areas.	Ensuring cultural competence in our evidence-based practices will require additional study and conversations with adults and youth in our service areas. We will seek to address the specific enculturation levels of the youth in the various service areas as we adjust our evidence-based practices to provide cultural competence for them.
Data relevant to the American Indian population are limited. Create and enhance a data collection system for assessment and evaluation.	Work with local schools to increase participation in the MiPHY. Work with other entities to increase access to existing data.

It is not yet clear if the best way to build a prevention system in the communities is through a coalition or a taskforce. Plans are in process for obtaining an MOU with SAFE in Northern Michigan, but the number of agencies is very limited in Harbor Springs and Pellston. Recall that the overall population in these two communities ranges between 1,500 and 2,500. Given an emphasis on the native community, a taskforce of concerned citizens and organizations may be more feasible than a coalition. Please see the timeline in Appendix C that contains detailed information on specific activities and trainings scheduled throughout the entire grant period to address identified needs through the planning process.

Role of the Tribal Epidemiological Workgroup (TEOW)

The TEOW will continue to meet quarterly. Its tasks will include the identification of other existing data sources and the creation of an on-going surveillance system; the development of a system for collecting and storing all data; and a systematic process for analyzing and reporting on the data. The TEOW will assist with the development of appropriate measures for the evaluation of the SPF TIG. They will also develop methods to make the needs assessment and evaluation data accessible and understandable to the larger tribal community as a whole. The TEOW will make a concerted effort to identify data sources, or develop new data sources, that are directly relevant to the LTBB tribal community. The TEOW has already begun developing relationships with local police and hospitals, as well as state agencies to address existing consequence and consumption data gaps. Staff and AC members will work with the schools in an effort to increase participation in the MiPHY and, ultimately, to increase the data available for American Indian students in both Emmet and Charlevoix Counties. The TEOW will add new members to the group, as it identifies potential partners in its data gathering effort. The group also plans to present the available data for discussion at tribal-specific events, to increase awareness of the issues and to gain help in future data collection efforts. Please see Appendix E: Tribal Epidemiological Outcomes Workgroup Charter for the actual guidelines and plans for data collection.

Role of the Tribal SPF TIG Advisory Council

The SPF TIG Tribal Advisory Council will continue to meet monthly during the initial planning and implementation phase of the SPF. Its role will be to oversee and assist with the overall implementation of the SPF process in Emmet County and in the three service areas. The AC will be asked, in particular, to assist with reaching and training the communities on SPF related issues and evaluation of the on-going implementation process. On-going training for the AC regarding the SPF process, evidence-based strategies, and capacity building has been incorporated into the SPRING timeline (Appendix C).

Ongoing Planning

Tribal – Infrastructure Development Plan

As noted earlier, the LTBB service area covers 27 counties, but the greatest number (941, 58.4%) of tribal members reside in Emmet County. Because of the large concentration of LTBB members residing there, the AC has chosen to focus the SPRING SPF TIG efforts in Emmet County. Within Emmet, the AC decided at its December 14, 2010, meeting to expend its grant funds in the county as a whole and in three specific service areas: Harbor Springs, Pellston and Petoskey. These service areas were chosen because of the number of tribal members living in each one and because of potential resources, such as existing organizations, that could be utilized for the implementation of the SPF. According to the 2000 Census, Petoskey (population of 6,080) is considered an urban area, but both Harbor Springs (1,567) and Pellston (2,501) are rural. Petoskey has twice as many tribal youth in their schools as does Pellston, and four times the number in Harbor Springs. In Harbor Spring, 22.3% of the population was under the age of 21. In Pellston and Petoskey, the percentages were 36.7% and 27.7% respectively.

Given Petoskey's higher number of tribal youth, a greater number of prevention resources, and an existing relationship with the SAFE coalition, the AC decided to begin full implementation of the SPF in this community. The hope is that by starting with a community with more resources, there would be a greater chance for success. Once the staff learns from Petoskey's implementation experience, they could then bring the SPF to Harbor Springs and Pellston. In the meantime, the staff will begin working on capacity development in the latter two communities, with an emphasis on prevention-focused training, and developing the infrastructure needed to implement the SPF process. This most likely will include the creation of a coalition or taskforce in each community, possibly in conjunction with the SAFE coalition. A particular focus of the SPRING project will be the recruitment of LTBB tribal members and/or individuals who identify as American Indian. Due to the nature of small service areas, efforts in all of the service areas may necessitate some collaboration with the broader community. SPRING staff are discussing plans for doing additional interviews to get a better sense of the key leaders in each community. At the very least, staff and the AC want to recruit tribal leaders, elders, youth, business owners, and parents.

Based on key stakeholder interviews and youth focus groups, the assessment of readiness to address UAD was somewhat mixed. In Harbor Springs, three out of the nine stakeholder interview respondents said their tribal community was ready to address UAD. In Pellston, three out of eight agreed; in Petoskey four out of eight; and thirteen out of twenty-three respondents from throughout the county thought tribal members were ready to address UAD. There was some concern raised about parental denial of the issue, but several respondents suggested that parental denial is not unusual. It was also thought that the communities would be more willing to initiate and sustain prevention activity if key community leaders were involved.

The Health Department of Northwest Michigan has received block grant funding for prevention. A new community health center has been opened in Pellston High School and it provides free health care and mental health services for school age children in the area. One of the SPRING staff members previously worked as a prevention specialist for the Health Department and another is very involved in the Pellston schools. In addition, the Pellston schools have received a 21st Century grant for after school and summer programs. Harbor Springs does not appear to have many prevention dollars, although there is some prevention programming being implemented in the Harbor Springs Middle School. The LTBB administrative offices are located in Harbor Springs and are an important resource. The SPRING staff is also exploring options for collaborating with other entities in the provision of prevention services. The addition of the prevention coordinator from NMSAS (the regional substance abuse coordinating agency) may also assist with the development of collaborative opportunities.

Tribal – Action Plan

LTBB's priority issue is the reduction of underage drinking (UAD). We will do so by implementing evidence-based strategies aimed directly at the IVs (social access, social norms, and perceptions of risk) and their associated CFs identified through the needs assessment (refer again to the logic model, depicted in Figure 7). Again, local communities may choose all of the IVs and CFs identified in the UAD logic model, or only those they consider to be special priorities. We would like to be able to specify by how much we expect to reduce underage drinking (as measured by past 30-day use), and the change expected in the IVs and CFs; however, we do not have any trend data which would assist with the setting of a realistic outcome. Our plan for implementing these strategies is discussed below.

Evidence-Based Programs, Policies, and Practices

The Evidence-Based Practices workgroup (EBP), consisting of SPRING staff members, is currently creating a menu of programs, strategies, policies and practices from which communities will choose for implementation. The workgroup has had some guidance from the Michigan EBP workgroup and will utilize some of the documents they create. The SPRING team is currently reviewing research to ensure that the menu will only include options that have shown a positive impact on their identified priority issue, intervening variables, and contributing factors. All options are also being reviewed for cultural appropriateness and the EBP may make recommendations for culturally relevant modifications. A definition of culturally relevant is still being developed, but at the very least will align with the Teachings of the Seven Grandfathers of Anishinaabe. Anishinaabe (the people) refers to a large group of Odawa and other tribes whose languages are mutually intelligible. These teachings include:

- *Nibwaakaawin*—Wisdom
- *Zaagi'idiwin*—Love
- *Minaadendamowin*—Respect
- *Aakode'ewin*—Bravery
- *Gwayakwaadiziwin*—Honesty
- *Dabaadendiziwin*—Humility
- *Debwewin*—Truth

There are not many evidence-based practices, programs or policies that have been tested with tribal youth. The staff will rely on the expertise of the AC and the tribal community members to decide which strategies are appropriate for implementation and which, if any, may need to be adapted to implementation with the LTBB population.

Planning – Allocations Approach

For the purpose of this grant, we are considering Emmet County to be **one** community, with three service areas: Petoskey, Pellston, and Harbor Springs. Petoskey will be the focus in the first year of strategy implementation, with Pellston and Harbor Springs each receiving assistance to enhance their prevention capacity. The SPRING project is currently working to hire an individual with community organizing skills, as well as substance abuse prevention background, to serve the entire community. There are no plans to hire a staff member for each of the service areas, because current staff live and are active in each of the service areas.

Using a collaborative planning approach, SPRING staff and AC members will work with the SAFE coalition in Petoskey and a coalition or taskforce in Harbor Springs and Pellston (once they are developed) to create plans to identify and implement the most appropriate evidence-based strategies (drawn from a menu of options currently being developed by SPRING staff) to address the contributing factors that lead to UAD. Plans will be reviewed by both the staff and the AC.

SPRING staff and AC members will work with SAFE (if they choose to establish groups in Pellston and Harbor Springs) to identify and recruit members for the community groups. A high priority is the recruitment of tribal residents and leaders for each of the communities. Again, the membership may not be exclusively tribal members, but the AC stated at its January 2011 meeting that a significant focus had to be on the recruitment and training of native people.

LTBB will be the fiduciary agency for the grant and will reimburse any agencies or groups for expenditures incurred for SPF implementation. Each service area will be asked to submit a budget to the SPRING staff, once they have created a local plan. At the January 2011 AC meeting, it was decided that the SPRING project coordinator would need to sign off on any budget requests prior to disbursement of funds and that requests have to align with the local implementation plan. Any request for services/materials over $5,000 must go through an LTBB bidding process. Criteria for successful bids include a preference for tribal member owned or provided services (See Appendix G for guideline detail). All SPF TIG training will be coordinated with LTBB, who will conduct or pay for training. If additional services are needed for the implementation of the SPF, a “purchase of service” may be initiated by the staff. In sum, LTBB is serving as the tribal and community-level organization for this grant and will ensure that the SPF TIG is implemented in each of the targeted service areas. The SAFE coalition and community coalitions/taskforces will be encouraged to use SPRING funds to leverage other funding in implementing prevention for LTBB tribal members. Funding will not necessarily be divided equally between all three service areas.

Although the SAFE coalition is mostly based in Petoskey, many of their activities extend throughout the county. Currently the SAFE coalition meets monthly, with adult and youth groups. It is anticipated that any group formed in Harbor Springs and Pellston will also meet on a monthly basis. SPRING staff will facilitate the initiation of new coalitions or taskforces, but they are very clear that the local groups must be led by non-SPRING staff. SPRING staff have discussed the option of county-wide training on the SPF process and activities, as well as on capacity building at the community level, but there is a concern that transportation may prove to be a tall barrier at this level. There may need to be separate trainings in the different service areas. Training will be coordinated with SPRING's Project Officer, C-RET, the contracted epidemiologist, and PIRE.

The EBP workgroup will create a menu of acceptable strategies from which coalitions or taskforces from the service areas can implement. All options on the menu will be reviewed by the EBP workgroup for cultural relevancy and include recommendations for enhancing relevancy if necessary. Local coalitions/taskforces with whom the tribe is working will submit a plan detailing their targeted IVs and CFs, strategies chosen that are linked with positive IV/CF outcomes, and a plan for implementation. The plan will need to be approved by SPRING staff if it includes request for funding for prevention activities.

SPRING staff will continue to work with the service areas throughout the implementation step and assist with the development of a sustainability plan for both the SPF process and the implemented activities. Right now, the only LTBB substance abuse prevention staff and activities are those funded by the SPF TIG project. Part of the sustainability plan for the tribal organization might include substance abuse prevention training for the whole LTBB organization (many personnel are active members in their communities and this would also assist community efforts). Efforts are already being made to identify and apply for additional funding to expand the prevention efforts.

Planning - Implications of Allocation Approach

As described previously, members of the LTBB are dispersed throughout the state of Michigan and the LTBB service area covers 27 counties. Nevertheless, the majority of LTBB members live in Emmet County. Therefore, we believe it is appropriate and prudent to concentrate our efforts in three locations within Emmet County, where the impact of the SPRING project will be greatest. In addition, tribal policies do not allow us to directly fund local coalitions or taskforces in the service areas. Thus, we will not fund "sub recipient" communities, as is typical with most SPF SIG grantees. Instead, we will collaborate with local coalitions and/or taskforces to plan and implement services, for which we will directly pay. As such, we consider ourselves **one** community for planning, implementation, and reporting purposes.

There may be some negative responses to the decision to begin in only one county. However Charlevoix, the county with the next highest LTBB membership, lies within the area which is also serviced by the Grand Traverse Band of the Ottawa and Chippewa Indians (GTB), a cohort III SPF TIG grantee. Thus, we anticipate that Charlevoix will already be gaining some SPF capacity through GTB's efforts. In addition, the relationship between these two counties is close (e.g., the counties are served by a single school district and are served by many of the same agencies); therefore, AC members felt that SPRING's capacity building and implementation efforts would eventually spread to Charlevoix as well. Thus, Charlevoix will ultimately have the benefit of two TIGs, even if it is not directly targeted by SPRING.

The LTBB Grant Writer is actively seeking other grants that might support the new prevention effort. There are currently no other tribal fiscal resources available for supporting the identified priority issue, although there is a clear willingness on the part of several departments (Law Enforcement, Youth Services and Education) to support the prevention efforts through in-kind services.

Implementation

Implementation of SPF TIG tribal and community plans will be periodically reviewed by the SPRING Advisory Council. The activities will be overseen and managed by SPRING staff. Community plans will need to be approved by the SPRING staff, particularly if they involve funding for prevention activities, to ensure that they are following the SPF steps and choosing evidence-based practices. As mentioned previously, SPRING staff have participated in some of the MI EBP workgroup meetings and will utilize some of their documents and guidelines, which are based on CSAP's guidelines. Staff will work closely with the community coalitions or taskforces in their implementation process. They will ensure that the communities receive the training needed to successfully implement their chosen strategies.

SPRING staff are currently holding discussions with the SAFE coalition in Petoskey to determine when and how they might work together on joint prevention efforts. Once they have agreed to mutual operating principles, they will develop an MOU. MOUs with additional partners will be pursued as needed; however, small, rural service areas tend to be less formal and MOUs may not be as necessary as in larger communities. Schools, police, hospitals, the public health department, treatment agencies, youth groups, among others are already represented on the SAFE coalition. Appendix C includes a detailed timeline with milestones for the remainder of the SPRING grant.

Training and technical assistance needs will be identified by staff in conjunction with the local communities. One of the plans is to continue key stakeholder interviews in the community, both to assess change in readiness, capacity development, and to identify training needs. There have been discussions with C-RET on how to make trainings available to the broader community as well as to staff.

Evaluation

LTBB has contracted with the Pacific Institute for Research and Evaluation (PIRE) to lead the SPF TIG evaluation and assess tribal activities and outcomes. PIRE is a nationally-known, not-for-profit research institution, with 34 years of experience researching and evaluating efforts to increase social and emotional well-being of people in the United States and around the world. The PIRE evaluation team for this project consists of two experienced evaluators. Dr. Marguerite Grabarek, based in Ann Arbor (MI), will be the Evaluation Director. She will be responsible for co-developing and implementing the evaluation. Dr. Al Stein-Seroussi, based in Chapel Hill (NC), will serve as the senior evaluation advisor. He will assist Dr. Grabarek in developing the evaluation work plan and will be available to consult with her on a regular basis. Drs. Grabarek and Stein-Seroussi also collaborate as the evaluators for the NY SPF SIG and collaborated on the recently-completed MI SPF SIG evaluation. In addition, Dr. Stein-Seroussi leads the evaluations of the NC and USVI SPF SIGs, while also serving on the national cross-site evaluation team for SPF SIG cohorts I and II.

Tribal Level Evaluation Activities

PIRE will implement a multi-level evaluation of SPRING. At the highest level, PIRE will focus on the extent to which the tribe successfully adheres to the five SPF steps. PIRE will assist the SPRING staff with the monitoring of: (a) their fidelity to evidence-based strategies and (b) their outcomes, including indicators related to UAD, as well as the IVs and CFs.

The evaluation is designed to address the following four questions, at both the tribal and local levels:

1. How has LTBB implemented the SPF TIG?
2. Has substance abuse prevention capacity increased as a result of the SPF TIG?
3. Has underage drinking (30 day use) among middle school, high school and college age youth been reduced as a result of the SPF TIG?
4. Have substance use and its related problems, including those represented by the National Outcome Measures (NOMs), been prevented or reduced? (specifically related to UAD)

PIRE will use the following methods to form a dossier of all major SPF TIG activities as they relate to the five SPF steps:

Document Review. PIRE will review key tribal documents, including the LTBB needs assessment and strategic plan, and meeting minutes for the TEOW, AC and EBP workgroups. PIRE will also review community plans for implementing evidence-based strategies.

Key Informant Interviews with Tribal and Community Stakeholders. PIRE will conduct annual interviews with key tribal stakeholders responsible for the implementation of the SPF TIG to document changes in tribal system capacity and progress with the implementation of the SPF. PIRE will conduct semi-annual key informant interviews with the project director, project coordinator and other relevant parties at the discretion of the project director.

Participation in Tribal Advisory Council and TEOW Meetings. PIRE will meet in person with SPRING staff five times during the second year of the evaluation contract (ending 6/30/2011) and agreed upon with LTBB in the following years. PIRE will attend at least five AC meetings in person, and via phone and web-conferencing as needed. They will also participate in other Tribal-level meetings by conference call as they occur, and will participate in monthly phone calls with Tribal project staff to keep abreast of major SPF related activities.

PIRE will use information from the above-cited methods to help LTBB complete the Grantee Level Instrument (GLI) required by CSAP at two points in time during the project. The GLI tracks Tribal level SPF TIG implementation and changes in Tribal-level prevention infrastructure and capacity.

Monitoring of Program Level Fidelity Data. PIRE will assist the SPRING staff with the use of instruments it developed for other SPF SIG evaluations to monitor program fidelity on a quarterly or semi-annual basis. These fidelity checks not only provide data that may be used by the TEOW and evaluation team when trying to determine whether the SPF TIG had enough strength to generate changes (thereby increasing our chances to attribute any apparent changes to the SPF TIG), but also help ensure that local service areas are cognizant of the best practices and are regularly assessing their delivery of best practices. In this way, the fidelity instruments will serve as good project management tools.

Monitoring Tribal- and Community-Level Outcomes. To assess the selected outcomes, PIRE will work with the SPRING staff to develop appropriate measures for assessing change in underage drinking and the IVs and CFs. Our overall goal for our analyses will be to determine whether SPF TIG service areas (and the county as a whole) significantly influence indicators directly related to LTBB's priority issue of underage drinking. Because the broader population will likely be exposed to the SPF prevention efforts, the non-Indian population will not serve well as a comparison sample for the assessment of change. Another comparable county may be chosen as a comparison group.

Regarding the National Outcome Measures (NOMs), PIRE will work with the SPRING staff to ensure that we identify the appropriate NOMs and that we develop and use methods to capture those data. At the very least, data on 30-day use among middle school, high school and college age students under the age of 21 will be collected via the bi-annual MiPHY and annual tribal surveys. Data on the perception of risk from regular alcohol use and peer and parental approval of alcohol use will also be gathered for the same age groups and via the same sources, if the communities choose to focus on these issues. The SPRING staff, trained by PIRE and the epidemiologist, will then be responsible for collecting the NOMS data. PIRE will receive data from the staff and report them as required to Tribal and Federal stakeholders.

As part of the evaluation, LTBB will fully cooperate with the SPF TIG cross-site evaluation.

Cross-Cutting Components and Challenges

Tribal culture is not monolithic. In other words, there are many levels of enculturation particularly in tribes such as ours which have had centuries of European contact. There are many dimensions and levels of both tribal and Pan-American Indian identity and all phases of the SPF will have to address this complex reality. The tribe has begun to address the lack of tribal-specific data for use in evidence-based planning, but will need to more fully develop what they initiated in the assessment phase. We need to further explore with the tribal community, the various levels of enculturation among our youth and how that translates into "cultural competency" in our implementation. "Culture" will likely be defined in a variety of ways across subgroups of youth and across service areas. A key in the capacity phase will be to strengthen the identification of the youth with their heritage particularly as they interpret it, and to build on positive aspects of their extant culture which might be utilized in the other SPF steps. Our review of the literature indicated that few “culturally-competent evidence-based strategies” exist. Therefore in the planning and implementation phases, the staff will work with each of the local service areas to identify evidence-based practices (EBP) which can be modified for “culturally” appropriate implementation with minimum loss of fidelity. Not only will the strategies need to be appropriate for LTBB, but also for the youth who are the main focus of this project. Youth will be involved in the selection and implementation of the strategies.

One of the key goals for the LTBB SPF TIG project is to develop a prevention infrastructure and to enhance the capacity of the tribe to implement the SPF in the future. Much of the work that will occur in the capacity building area will be focused on fostering a sustainable process. To this end, the tribe will seek assistance with sustainability planning as soon as possible.

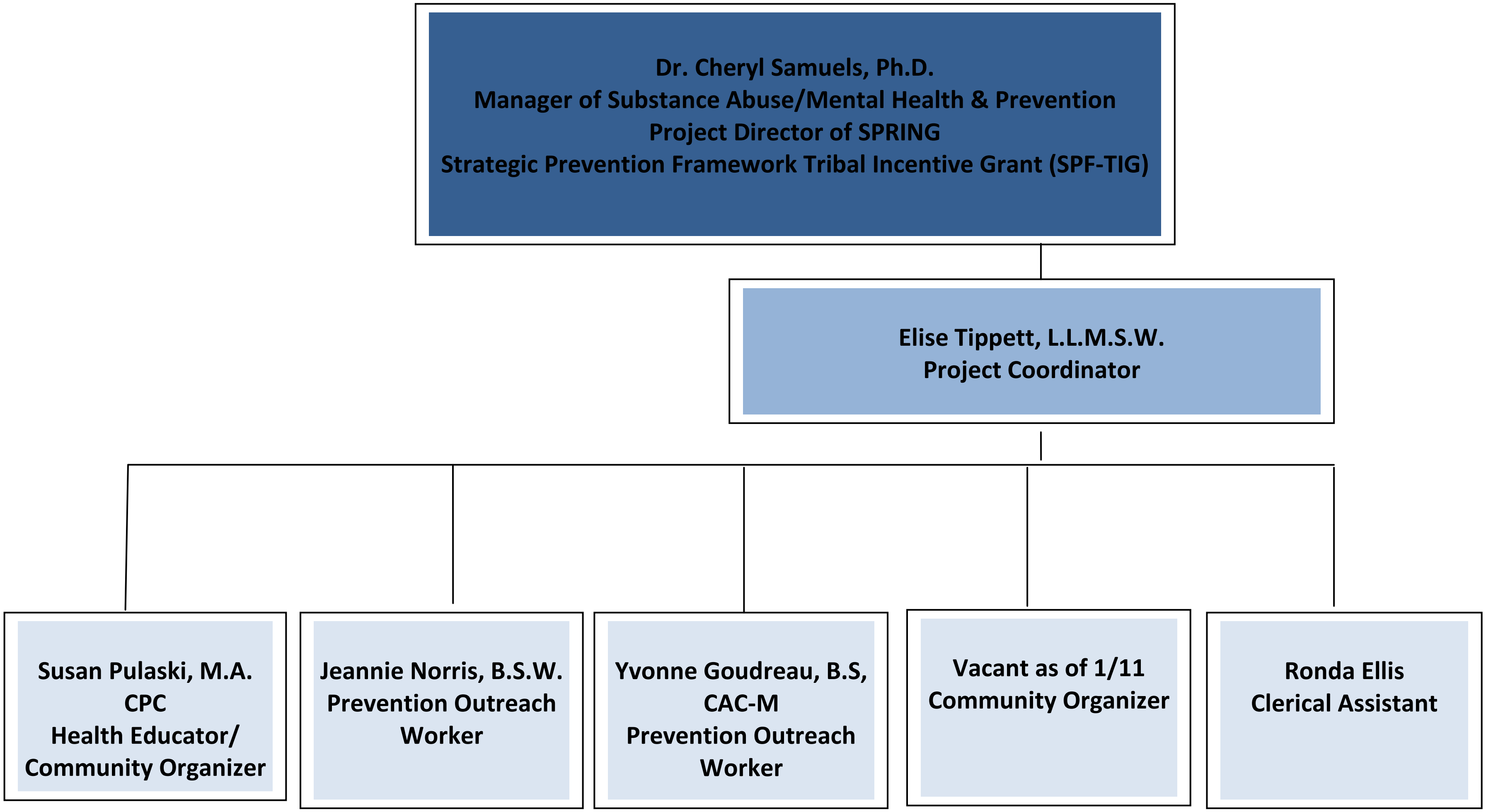
There will be some challenges during the implementation phase. Prevention and evidence-based prevention planning are new for the tribe. The SPRING staff will have to spend time in the service areas providing education about the concept and the importance of prevention. As previously mentioned, two of the service areas do not have a prevention group in place, so capacity building will have to occur not only for the initial phases of the SPF, but for the implementation phase as well. Transportation will also be a significant barrier, since it is not unusual for students to travel twenty miles just to get to school, and many people do not have cars to provide transportation to after school activities. It is hoped that SPRING staff can bring together the broader community, particularly the youth.

Conclusion and Final Thoughts

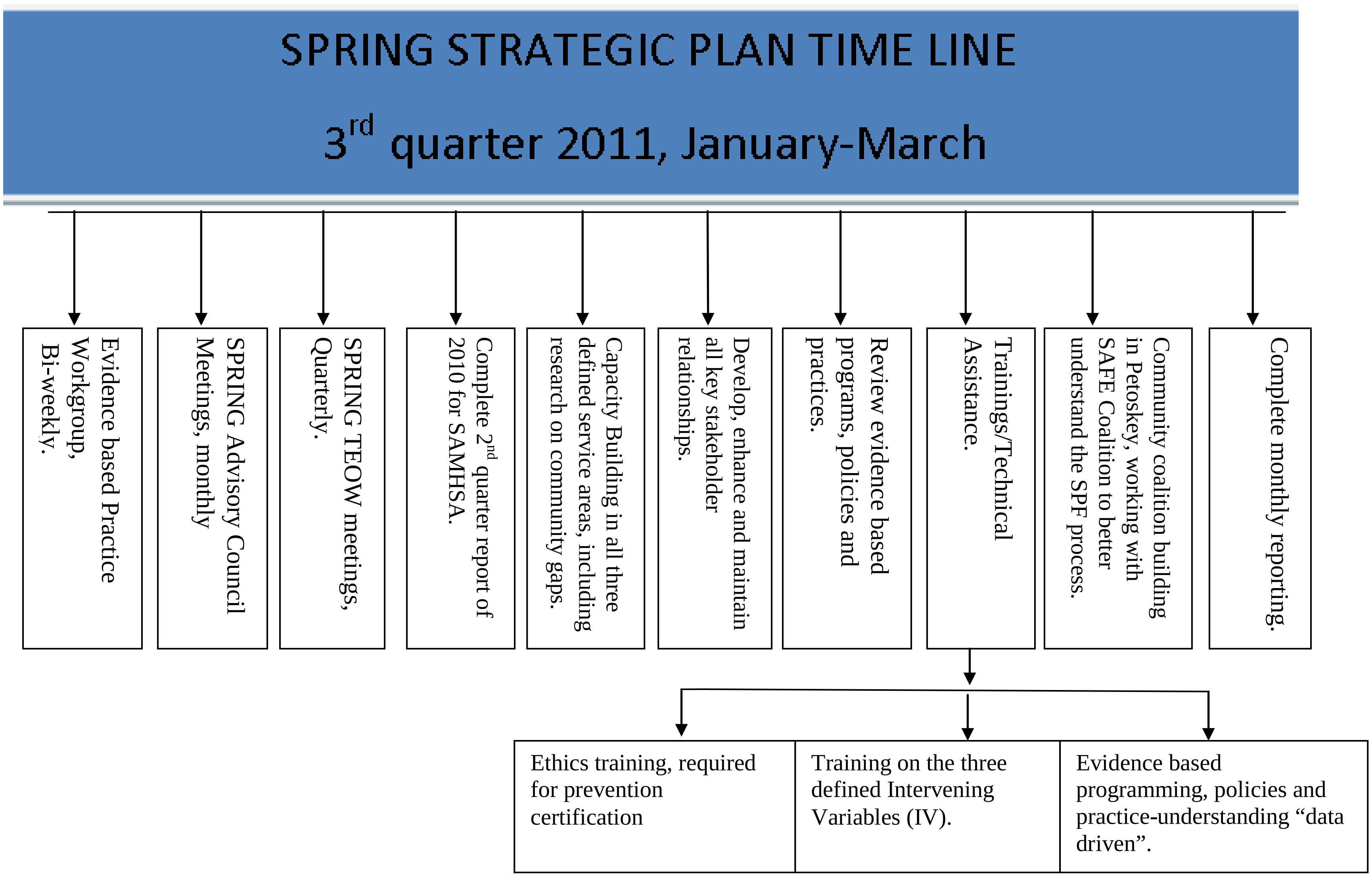
In conclusion, the survey data SPRING staff gathered indicate that underage drinking (UAD) is a significant issue in Emmet County. Accordingly, after reviewing our data with the SPRING AC, the AC decided that UAD will be the priority focus for the SPRING project. Further, after reviewing MiPHY student data, NCMC College data, key stakeholder interview and focus group data, the AC identified social norms, social access, and perception of risk as the Intervening Variables that contribute most to UAD. The AC also determined that Petoskey, Pellston, and Harbor Springs will be the selected service areas for SPRING. This SPRING Strategic Plan lays the framework for this project to be successful and sustainable in its efforts to reduce UAD.

SPRING represents a new beginning for LTBB. LTBB is an ancient tribe. Since the recent reaffirmation and reorganization procedures with the federal government, we have built a new formal tribal infrastructure with the goals of meeting the myriad needs of our tribal members. We are proud of our ability to provide care and compassion to our community members. SPRING is our first comprehensive attempt at preventing the substance-related ills that affect our people (and all people). It has been a huge challenge for us, as we have tried to better understand ourselves, our service areas, and our needs. It will be an even bigger challenge as we attempt to identify and implement evidence-based practices that might not have been developed with cultural considerations for the American Indian population. But we are up to the challenge. Our staff are ready. Our Advisory Council is ready. Our TEOW is ready. Our Evidence-based workgroup is ready. And, we will work tirelessly to help get our service areas ready for this unique opportunity.

Appendix B: SPRING Flow Chart



Appendix C: SPRING Planning Timeline



SPRING STRATEGIC PLAN TIME LINE
4th quarter 2011, April-June

- Evidence based Practice Workgroup, Bi-weekly.
- SPRING Advisory Council Meetings, quarterly.
- SPRING TEOW meetings, quarterly.
- Complete 3rd quarter report of 2011 for SAMHSA.
- Continue Capacity Building in all three defined service areas, including research on community gaps
- Continue developing, enhance and maintain all key stakeholder relationships.
- Develop work plan to build capacity in Petoskey, & collaboration on SPF process. Select EBP.
- Training/Technical Assistance
  - Training on selected EBP for Petoskey
  - Cultural Competence training-talking circles and storytelling.
  - Community Readiness training
  - Coalition Development 101/102, including Culture Comp.
  - The role of culture in developing effective strategies for LTBB.
- Community coalition building in Petoskey, working with SAFE
- Complete monthly reporting.
- Receive SAMHSA approval of strategic plan.

SPRING STRATEGIC PLAN TIME LINE
1st quarter 2011, July-September

- Evidence based Practice Workgroup, monthly.
- SPRING Advisory Council Meetings, quarterly.
- SPRING TEOW meetings, quarterly.
- Complete 4th quarter report of 2011 for SAMHSA.
- Implement strategies in Petoskey.
- Continue developing, and maintain all key stakeholder relationships and continue coalition work.
- Develop work plan to build capacity in Pellston, & collaboration on SPF process. Select EBP.
- Training/Technical Assistance
  - Design and development of electronic presentations
  - Involving youth in prevention programming
  - Social media training
  - Social marketing training
  - Collaboration at the community level
- Surveying community to update LTBB Epi Profile.
- Complete monthly reporting.
- Collect process and outcome data.

SPRING STRATEGIC PLAN TIME LINE
2nd quarter 2011, October-December

- Evidence based Practice Workgroup, quarterly.
- SPRING Advisory Council Meetings, quarterly.
- SPRING TEOW meetings, quarterly.
- Complete 1st quarter report of 2011 for SAMHSA.
- Implement selected strategies in Petoskey.
- Continue developing, and maintain all key stakeholder relationships and continue coalition work.
- Implement selected strategies in Pellston.
- Training/Technical Assistance
  - Training on the role of Indian culture in building resiliency factors.
  - Training on selected EBP for Pellston
  - Evaluation: Knowing When to Celebrate and How to Keep Improving
  - Working with grantee to overcome barriers to implementing environmental strategies.
  - Training on effects of alcohol and the brain
- Surveying community and updating LTBB Epi Profile.
- Complete monthly reporting.
- Continue implementation of evaluation plan.

SPRING STRATEGIC PLAN TIME LINE
3rd quarter 2012, January-March

- Evidence based Practice Workgroup, quarterly.
- SPRING Advisory Council Meetings, quarterly.
- SPRING TEOW meetings, quarterly.
- Complete 2nd quarter report of 2011 for SAMHSA.
- Implement selected strategies in Petoskey.
- Continue developing, and maintain all key stakeholder relationships and continue coalition work.
- Implement selected strategies in Pellston.
- Training/Technical Assistance
  - Implementing the SPF at the local level, Step1-5 for Harbor Springs
  - Training on the three defined Intervening Variables (IV) for Harbor Springs
  - Coalition development 101 & 102 Harbor Springs
  - Collaboration at the community level for Harbor Springs
  - Training on selected EBP for Harbor Springs
- Continue to build capacity in defined service area-Harbor Springs and develop local task force
- Complete monthly reporting.
- Continue implementation of evaluation plan.

SPRING STRATEGIC PLAN TIME LINE
4th quarter 2012, April -June

- Evidence based Practice Workgroup, quarterly.
- SPRING Advisory Council Meetings, quarterly.
- SPRING TEOW meetings, quarterly.
- Complete 3rd quarter report of 2012 for SAMHSA.
- Implement selected strategies in Petoskey.
- Continue developing, and maintain all key stakeholder relationships and continue coalition work.
- Implement selected strategies in Pellston.
- Training/Technical Assistance
- Implement selected strategies in Harbor Springs
- Complete monthly reporting.
- Continue implementation of evaluation plan.

Cultural Competence training-talking circles and storytelling. Harbor Springs	Evaluating environmental strategies	Using data to inform implementation	The role of culture in developing effective strategies targeted at Native American populations	Effective implementation and overcoming barriers of environmental strategies -HS

SPRING STRATEGIC PLAN TIME LINE
Year 4
July 2012 - June 2013

- SPRING Advisory Council Meetings, monthly
- SPRING Evidence Based Practice workgroup, quarterly
- SPRING Tribal Epidemiological Outcomes Workgroup (TEOW) meetings, quarterly
- Continue needed Trainings/Technical Assistance
- Continue assisting service areas with implementing of programs, policies and practices
- Continue assisting with Coalitions/Task Forces
- Collect annual process and outcome data
- Develop, enhance and maintain all key stakeholder relationships
- Complete monthly/quarterly reports
- Annual Grantee Meeting
- Surveying-trend data
- Continued evaluation

SPRING STRATEGIC PLAN TIME LINE
Year 5
July 2013-June 2014

- SPRING Tribal Epidemiological Outcomes Workgroup (TEOW) meetings, quarterly
- Continue needed Trainings/Technical Assistance
- Continue assisting service areas with implementing of programs, policies and practices
- Continue assisting with Coalitions/Task Forces
- Collect annual process and outcome data
- Develop, enhance and maintain all key stakeholder relationships
- Complete monthly/quarterly reports
- Annual Grantee Meeting
- Surveying-trend data
- Continued evaluation
- Sustain efforts of service areas

Appendix D: SPRING Advisory Council Guidelines

(Approved at the 12/14/2010 meeting)

Advisory Council:

The council is responsible for providing strategic and operational recommendations for the implementation of all steps of the Strategic Prevention Framework process including assessment, capacity, planning, implementation and evaluation as well as cultural competency and sustainability.

The Little Traverse Bay Bands of Odawa Indians Strategic Prevention Framework Tribal Incentive Grant (SPF TIG) Advisory Council (AC) is a multi-disciplinary team representing tribal, state, and local agencies. The AC was established in October 2009 and its unique membership of tribal members, state and community agencies and community and youth service organizations provides an ideal mix of perspectives to effectively guide SPRING. The Council is composed of member agencies from a cross-section of tribal government agencies and organizations that serve the health, mental, social, economic, familial, and justice needs of LTBB. The membership of the AC has recently been updated to include representation from the local Intermediate School District, Office of Veteran's Affairs, Regional Hospital, Communities (Pellston, Petoskey, and Harbor Springs), parents and LTBB Tribal Youth. The AC will likely to extend an invitation of membership to agencies and organizations as the opportunity is presented.

AC Primary Functions:

- Support full implementation of the SPF TIG in compliance with grant award requirements
- Provide input and guidance during implementation of the SPF
- Provide expertise, such as knowledge of special population, strategies and policy recommendations
- Provide ongoing feedback on emerging issues that may impact the successful implementation of the SPF TIG process
- To participate in a needs assessment of LTBB's readiness to address substance abuse issues.
- Identify, with the Tribal Epidemiological Outcomes Workgroup (TEOW), the information needed in order to prioritize needs for substance abuse prevention.
- Develop strategic prevention plan goals and measurable objectives.

AC Roles:

- Oversees the TEOW and will continue translating its findings and recommendations into actionable policies
- Assess agencies' contributions toward achieving outcomes in the strategic plan
- Through its Evidence-Based Practice (EBP) workgroup, the AC will continue to monitor selection and implementation of evidence-based policies and practices

- LTBB Anishinaabe culturally knowledgeable members enhance and ensure the cultural sensitivity of the AC, the TEOW, and the EBP workgroups.

AC Membership:
Members of the AC were invited based upon their knowledge and capacity for substance abuse prevention. Membership was also chosen to reflect as many experts in the substance abuse prevention field with expertise while keeping the council relatively small. Diversity on the AC reflects this effort with a mix of data analysts, epidemiologists, prevention experts, community providers, and Tribal representatives. The LTBB AC consists of 28 members, as well as many others who will serve as resources to share their knowledge and expertise. All members contribute a significant component that is necessary to complete the required grant deliverables. All members may assign a proxy to serve in the event that the original member cannot attend an AC meeting.

Table 1: Advisory Council Membership

Member	Role	Organization
Albert Colby Jr.	Member	Tribal Administrator
Bernadece Kiogima	Member	Tribal Court Administrator/Parent and Community member of Petoskey
Carolyn Foxall	Member	State of Michigan Bureau of Substance Abuse and Addiction Services (BSAAS)
Meh-May Gwaz Shomin	Member	LTBB Tribal Youth
Dean Samuels, Sr.	Member	Elder- LTBB Tribal Member
Denneen Smith	Member	LTBB Human Services Director
Dorothy Perry	Member	GBD Academic Services Coordinator K-12 Specialist
Meredith Henry	Member	LTBB Gijigowi Bipskaabiimi, Interim Title VII Coordinator Petoskey/Charlevoix
Jeff Cobe	Member	LTBB Chief of Police
Jim Rummer	Member	Char-Em Intermediate School District
Phil Harmon	Member	LTBB Human Resource Interim Director
Kara Copeland	Member	Alternative School Academy
Ken Harrington	Member	Tribal Chairman
Jim Alton	Member	Office of Veteran's Affairs
Kristy Dayson	Member	LTBB Youth Coordinator /Parent and Community member of Petoskey
Linda Ryden	Member	Central Regional Expert Team (C-RET)
Kathy McGraw	Member	LTBB Elder Program
Matt Lesky, J.D.	Member	LTBB Prosecuting Attorney/ Parent and Community member of Petoskey
Melissa Claramunt	Member	State of MI Department of Civil Rights
Patrick Boda	Member	Community member from Pellston
Sharon Sierzputowski, R.N.	Member	LTBB Health Department Director

Julie Kauppila	Member	LTBB Grant Writer
TBA	Member	School from identified service area
TBA	Member	School from identified service area
Melissa Wiatrolik	Member	Parent and Community member of Pellston
TBA	Member	LTBB youth from identified service area
Tonia Gray	Member	SAMHSA SPF TIG Project Officer
Tosha Bennington	Member	Parent and Community member of Pellston

Advisory Council Procedures:
Meeting:

1. Meetings are generally held the fourth Tuesday of each month.
2. At least one meeting per quarter must be held.
3. Special meetings may be called by the AC Tribal Administrator or Project Director. The LTBB Clerical Assistant shall notify all members of the AC by any means not less than two days in advance of such special meeting.
4. Agenda items should be submitted to the Elise Tippett at least 2 weeks prior to a scheduled meeting.
5. Agendas are sent out one week prior to the meeting.

Agenda:

- Administrative Business
    - Call Meeting to Order
    - Recording of Attendance
    - Approve Minutes
    - Set Order of Agenda
    - Communications Follow vote
- Open Comment Period
- Committee Reports
- Unfinished and Deferred Business
- New Business
- Other Business – as may be brought up by members
- Adjourn

Meeting Procedures:

- A quorum shall consist of a simple majority of all AC members.
- All voting shall be by voice vote or by a show of hands and the result of the voice or hand vote shall be kept as part of the minutes. Any matter before the AC that does not get either four affirmative or four negative votes shall be considered tabled until the next regular AC meeting.
- No binding or final action may be taken on any matter not on the written agenda except by a unanimous vote of the members in attendance.
- A tabling motion has the effect of laying the matter over until the next regular meeting unless otherwise specified.

- Whenever a AC member shall have a direct or indirect personal or financial interest, such member shall declare such interest and shall not participate as a member of the AC in any hearing, discussion or deliberations of such matter, and shall in no event vote on such matter.
- If a decision is required and there is not a quorum at the AC meeting, then key leadership and at least a majority of the AC will be asked to give their vote for the final decision via personal contact or electronic means.
- Any action approved will be reflected in the month's meeting minutes.

Appendix E: Tribal Epidemiological Outcomes Workgroup Charter

Using Epidemiological Data to Guide and Enhance Prevention Practice

TEOW Establishment:
The Tribal Epidemiological Outcomes Workgroup (TEOW) was created on May 2010 and is modeled after the National Institute on Drug Abuse (NIDA) community epidemiological workgroup. The TEOW is housed in the Little Traverse Bay Bands of Odawa Indians (LTBB), and is funded through a federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP).

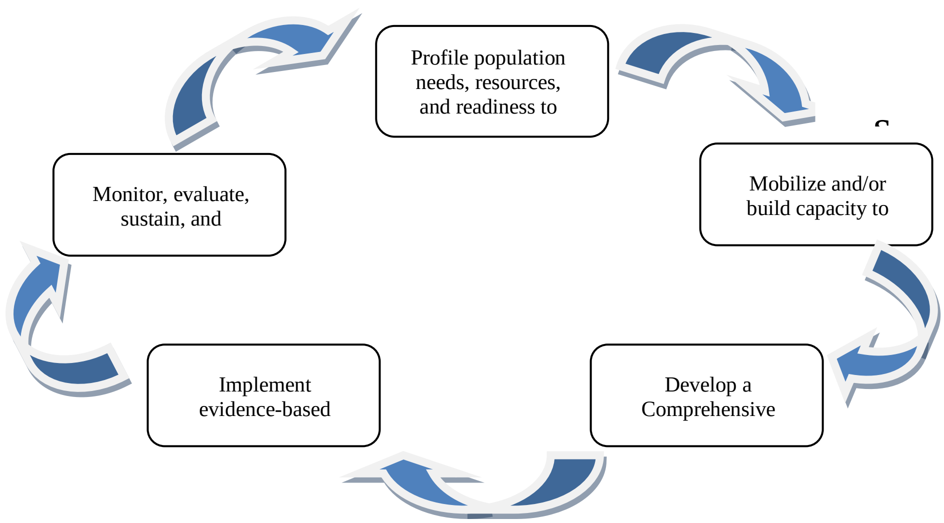
TEOW Program Mission:
The mission of the TEOW is to move toward the integration of data about the nature and distribution of substance use and related consequences into ongoing assessment, planning, and monitoring decisions at the Tribe and community levels. The TEOW is a network of people and organizations that bring analytical and other data competencies with expertise about alcohol, tobacco, and other drug (ATOD) substance abuse prevention. The TEOW aims to bring systematic, analytical thinking about the causes and consequences of substance use to substance abuse prevention planning so that prevention resources are used effectively and efficiently.

TEOW Program Goals and Objectives:
The TEOW focuses on using data to inform and enhance substance abuse prevention practice. Specifically, the TEOW examines and interprets data and assesses the implications of those data for prevention decisions. The TEOW most often engages in work that supports the SPF steps: Assessment, Planning, and Implementation but also to a lesser degree, supports SPF steps: Building Capacity and Evaluation. Furthermore, the TEOW focuses on building data capacity and infrastructure that will serve to strengthen data systems and competencies. The TEOW has been funded to develop Tribe and community-level epidemiological profiles; addressing data gaps and other data system challenges related to describing, interpreting, and applying epidemiological data findings; and developing dissemination and sustainability plans – all to improve decisions about enhancing prevention infrastructure and practice.
Within the TEOW effort, CSAP has defined a series of data driven activities to assist the further development of their monitoring system by:

- Developing a key set of indicators to describe the magnitude and distribution of substance related consequences and consumption patterns across the Tribe (i.e., an epidemiological profile).
- Collecting, analyzing, interpreting, and communicating these data through the development of an epidemiological profile.
- Establishing prevention priorities for Tribal resources based on data analyzed and interpreted through the profiling process.
- Allocating resources to populations in need for established priorities.

- Developing a systematic, ongoing monitoring system of tribal substance-related consumption patterns consequences and to track progress on addressing prevention priorities, detect trends, and use such information to redirect resources if needed. Thus, the Tribe's epidemiological profile can become a "living document" rooted in the Tribe's substance monitoring system.

Figure 1: SAMHSA's Strategic Prevention Framework Implementation Steps



Through each of the SPF steps, the TEOW provides support that is essential to the success of the projects:

1. Assessment: TEOW collect, analyze, interpret a set of epidemiological data elements and describe substance-related consequences and consumption patterns in an epidemiological profile.
2. Capacity Building: TEOW provides data and information to key stakeholders to mobilize and enhance Tribe and community resources to address prevention priorities and may assist the Tribe collect, analyze, and interpret prevention system capacity data.
3. Planning: TEOW determine key substance-related problems (i.e., specific consequences or substance use patterns, target populations, geographic areas), and provide these findings to guide Tribal decisions about prevention priorities and Tribe allocation of prevention funds.
4. Implementation: TEOW may work with the Tribe and communities to determine strategies that are aligned with and effectively address identified priorities.
5. Evaluation: TEOW conducts ongoing data collection and analysis to examine changes over time in substance-related problems and patterns of consumption and feed this information into ongoing Tribal decisions about prevention priorities and resource allocation.

TEOW Key Principles:
Three key principles have guided the development and functioning of the TEOW

1. Emphasis on **outcomes-based prevention**.
2. Adoption of a **public health approach** to preventing and reducing substance use and related problems.
3. Utilization of **epidemiological data** as a primary foundation for all planning and decision-making.

Outcomes-Based Prevention:
Before the Tribe can determine what strategy(s) to fund, it is critical to begin with a solid understanding of the outcomes to be addressed. Outcomes-based prevention starts with a focus on substance use and related consequences among populations. Understanding the nature and extent of substance related problems is critical to identifying the underlying factors contributing to such problems (intervening variables) and ultimately choosing prevention strategies with the expectation of changing targeted consequences and consumption patterns. Data reflecting consequences and associated usage patterns serve as a foundation for ongoing monitoring and evaluation activities to track and improve prevention efforts.

Public Health Approach:
The public health approach to reducing substance use and related consequences focuses on preventing health problems and promoting healthy living for whole populations. Substance abuse prevention has been more individual- or person-centered, reflecting its close association with substance abuse treatment. Prevention research, however, has demonstrated that prevention approaches that broadly target population level change are effective producing measurable improvements in harmful consumption patterns and negative consequences in groups as a whole.

Epidemiological Data:
Epidemiology is the study of the distribution and determinants of health-related events in populations. Epidemiological data describing the extent and distribution of substance use and the consequences of substance use within and across population is vital to a successful prevention initiative that embodies outcomes-based prevention and a public health approach. Such data allows the Tribe to begin answering basic questions that serve as a foundation for data-driven prevention planning: What are the consequences of substance use? What substances are being used? By whom? How? Where?

TEOW Expectations:
The TEOW will complete the CSAP identified six core tasks that will result in the establishment and effective functioning of the TEOW:

1. Develop a Tribal-level structure that focuses on using data for decision making related to substance abuse prevention

2. Identify the types and scope of data needed to describe the magnitude and distribution of Tribal-level substance use and related consequences across the lifespan.
3. Collect and analyze data on substance use and related consequences
4. Assist in setting substance abuse prevention priorities based on epidemiological data and outline how they inform Tribe planning and resource allocations
5. Assist in identifying, collecting, and analyzing community-level data and in determining the use of those data in community planning
6. Develop a system for ongoing monitoring of substance abuse-related data to track the progress of efforts to address prevention priorities and for detecting trends.

TEOW Membership:
Members of the TEOW were invited to be part of the needs assessment process based upon their knowledge and capacity to work with substance-related data. This includes the ability to bring raw data sets and the analysts needed to evaluate the data. Membership was also chosen to reflect as many experts in the substance abuse prevention field with expertise in data while keeping the workgroup relatively small. Diversity on the TEOW reflects this effort with a mix of data analysts, epidemiologists, prevention experts, community providers, and Tribal representatives. The LTBB TEOW consists of **15** members, as well as many others who will serve to share their knowledge of relevant resources. All members contribute a significant component that is necessary to complete the required grant deliverables and the epidemiological profile. All members may assign a proxy to serve in the event that the original member cannot attend a TEOW meeting.

Table 1: Tribal Epidemiological Outcomes Workgroup Membership

Member	Role	Organization
Leslie Ballenger, DrPH	Chair	Epidemiologist
Susan Pulaski, M.A.	Vice-Chair	LTBB SPRING Health Educator
Cheryl Samuels, Ph.D.	Member/Program Director	LTBB SPRING Project Director
Elise Tippett M.S.W.	Member	LTBB SPRING Grant Coordinator
Jeannie Norris BSW	Member	LTBB SPRING Youth Assistant
Marguerite Grabarek, Ph.D.	Member	Pacific Institute for Research & Evaluation
TBD	Member	LTBB SPRING Community Organizer
Yvonne Goudreau	Member	LTBB SPRING Prevention Outreach Worker
Ronda Ellis	Member	LTBB SPRING Clerical Assistant
Jim Rummer	Member	Char-Em Intermediate School District
Marie Helveston	Member	Northern Michigan Substance Abuse Services
Jeff Cobe	Member	Chief of Police
TBD	Member	Sheriff’s Department
Ken Mills	Member	Drug Enforcement Agency
TBD	Member	Northern Michigan Regional Hospital

TEOW Procedures:

The TEOW will meet quarterly as shown in Figure 2. The TEOW will meet on the Monday preceding the Advisory Council (AC) meeting with the anticipation of presenting updates and addressing questions of the AC.

Meeting:

A) Meetings are generally held the **4th Monday** of each month beginning at **2:00 p.m.** in a designated room at LTBB Health Clinic.

B) At least one meeting per quarter must be held.

C) Special meetings may be called by the TEOW Chair or Vice-Chair or at the request of the Advisory Council. The LTBB Clerical assistant shall notify all members of the TEOW by any means not less than two days in advance of such special meeting.

D) Agenda items should be submitted to the Chair and Vice-Chair at least 5 days prior to a scheduled meeting.

E) Agendas are sent out on Tuesday or Wednesday of the week prior to the meeting by Chair or vice-chair.

F) The Chair or Vice-Chair will send a memo to all TEOW members asking whether they have any issues to come before the TEOW two weeks prior to the meeting.

Agenda:

- Administrative Business
    - Call Meeting to Order
    - Recording of Attendance
    - Approve Minutes
    - Set Order of Agenda
    - Communications Follow vote
- Open Comment Period
- Committee Reports
- Unfinished and Deferred Business
- New Business
- Other Business – as may be brought up by members
- Adjourn

Meeting Procedures:

- A quorum shall consist of a simple majority of all TEOW members.
- All voting shall be by voice vote or by a show of hands and the result of the voice or hand vote shall be kept as part of the minutes. Any matter before the TEOW that does not get either four affirmative or four negative votes shall be considered tabled until the next regular TEOW meeting.
- No binding or final action may be taken on any matter not on the written agenda except by a unanimous vote of the members in attendance.
- A tabling motion has the effect of laying the matter over until the next regular meeting unless otherwise specified.
- Whenever a TEOW member shall have a direct or indirect personal or financial interest, such member shall declare such interest and shall not participate as a member of the TEOW in any hearing, discussion or deliberations of such matter, and shall in no event vote on such matter.

- The TEOW may temporarily suspend its rules by a 2/3 vote of members in attendance.

TEOW Meeting Schedule:

Figure 2: TEOW and AC Meeting Dates and Deliverable Timeline

APRIL 2010

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23 30	24	**25**	26	27	28	29

MAY 2010

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	**23**	24	25	26	27
28	29	30	31			

JUNE 2010

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	**15**	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

JULY 2010

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	**27**	28	29	30	31

AUGUST 2010

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	**24**	25	26	27	28
29	30	31				

SEPTEMBER 2010

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	**28**	29	30		

OCTOBER 2010

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	**26**	27	28	29	30

NOVEMBER 2010

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	**23**	24	25	26	27
28	29	30				

DECEMBER 2010

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	**28**	29	30	31	

JANUARY 2011

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	**25**	26	27	28	29

FEBRUARY 2011

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	**27**	28			

MARCH 2011

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	**22**	23	24
25	26	**27**	28	29	30	31

TEOW Meeting Dates (4th Monday of Month)

TEOW Deliverables

August 13, 2010	Final Survey Instrument Developed
August 16, 2010	Final Draft TEOW Charter, Mission, Goals, Timeline
August 20, 2010	Training SPRING staff on survey administration
August 23, 2010	Approval of TEOW Charter, Mission, Goals
August 24, 2010	Key Informant Interviews of Advisory Council Members
August 26, 2010	Survey Data Collection - Tribal Employees
August 30, 2010	Survey Data Collection - Pow wow

August 31, 2010	Survey Data Collection - College/University
September 22, 2010	Draft Epidemiological Profile
October 15, 2010	Final Epidemiological Profile
October 26, 2010	Present Epidemiological Profile & Findings to Advisory Council
November 22, 2010	Prioritization Process - Priority Selected by Advisory Council
December 31, 2010	Draft Strategic Plan
January 14, 2011	Draft Strategic Plan
January 25, 2011	Present Strategic Plan to Advisory Council
January 27, 2011	Draft Strategic Plan
February 15, 2011	Strategic Plan Due to CSAP

Advisory Council Meeting Dates (4th Tuesday of Month)

Appendix F: Key Stakeholder & Focus Group Questions

1. What do you think is going on in the **community** that causes or supports underage drinking?

Broader	Tribal

2. Where do you thing youth are getting alcohol?

Broader	Tribal

3. Where do you think youth are doing their drinking?

Broader	Tribal

4. What types/groups of youth are using alcohol?

5. What do you think is going on in **families** that **causes or supports** underage drinking?

Broader	Tribal

6. What do you think is going on among **Youth** that **causes or supports** underage drinking?

Broader	Tribal

7. What is already in place or a strength in our community to help prevent underage drinking?

Broader	Tribal

8. How ready do you think our **broader community** is to do something about underage drinking?
   What do you think about the leadership in our community?
   Are they ready to do something about underage drinking?

Broader	Tribal
Leadership:	Leadership:
Readiness:	Readiness:

9. If we were going to do something about underage drinking in our community, what might stop us or get in the way?

10. Can you suggest the names of anyone else (especially youth under 21) we should talk to about this issue and/or include in our efforts to do something about this issue?

Interview Information Sheet

We asked you to participate because we value your opinion as a Key Stakeholder regarding underage drinking. Your **(ROLE)** for this process is **______________________**, how long have you been in this (**ROLE)**:**_____________**

Zip code:**_________________**

Time lived in this town/community: ___________________

Gender: **___**Male **___**Female

Age (please check):

___12-17 yrs

___18-25 yrs

___26-35 yrs

___36-45 yrs

___46-55 yrs

___56-65 yrs

___66yrs and older

Race:
___ African American/Black
___ Asian American
___ Hispanic/Latino
___ American Indian/Alaskan Native
___ Native Hawaiian or other Pacific Islander
___ White/Caucasian
Other: **_______________________**

If affiliated with a Tribe, which Tribe:**___________________________**

Appendix G: LTBB Purchasing Policies

Title: **PURCHASING POLICY AND PROCEDURES**

Policy: Procurement of all inventory, supplies and capital equipment will be facilitated through the Purchasing Department. The Purchasing Department will be responsible for using good purchasing methods for optimizing price savings, quality or value of products, vendor working relationships, and for assuring proper inventory control and inspections as required byTribal policies and all regulatory and customer contract requirements.

Purpose: To provide procedures for procurement methods and completion of related documents.

Scope: This procedure applies to the purchase of all inventory items, supplies, food, catering, special events and capital equipment for all departments within the Tribal Government. For Capital items additional policies and procedures May apply.

Procedure: PURCHASING PROCEDURES

1.0 VENDOR SELECTION

1.1 Vendors can be evaluated and selected using the following criteria:

- Pricing.
- Parts availability and shipping time frame.
- Performance capability (i.e., financial status, sufficient facilities, equipment and employees).
- Internal Quality Assurance program.
- Past performance.

Qualified vendors will be maintained on an Approved Vendor List for purchasing use.

For first time purchases from a vendor, a New Vendor Notification form (Exhibit 1) should be completed and approved. Any related party transactions or vendors that the Tribe or employees could have a potential conflict of interest with, should be documented on this form. The form will be maintained in the vendor file with a copy to accounts payable. Only when a related party transaction is identified will it be distributed to the Tribal Administrator and CFO.

2.0 VENDOR FILES

2.1 A vendor file will be prepared and maintained for all vendors on the Approved Vendor List which will be used for significant or on-going purchasing. The vendor files will be kept alphabetically and may include the following:

- New Vendor Notification form.
- Completed credit applications and terms.
- Resale certificates.
- Legal contracts .
- Long-term blanket purchase order commitments.
- Vendor Survey Forms.
- Any other relevant correspondence or documentation.
- Documentation of 51% Tribal ownership

3.0 ORDER DETERMINATION AND REQUISITION

3.1 The program Director, manager or coordinator will complete a Purchase Requistion (Exhibit 2). Requisitions should be completed and approved with the following items and any additional supporting documentation:

- Complete description with part or model numbers if available.
- Quantity required.
- Date required.
- Requesting department and accounting code PROGRAM NUMBER and account to be charged.
- Recommended vendor or source if applicable.
- Estimated Cost or not to Exceed Amount

The Staff accountant will verify the budget and allowability of the item, initial the coding and forward to purchasing for processing.

Purchasing will analyze terms, vendor, pricing, quantity breaks, etc., and will order accordingly in the Tribe's best interest. Purchasing will notify the requester of any material variances prior to placement of the order.

3.3 Vendor selection will be in accordance with the Tribe's procedures for Vendor Selection and Files.

4.0 ORDER PLACEMENT

4.1 Purchasing will be responsible for completing a Purchase Order (Exhibit 3) for all orders. The Purchase Order should be completed with all applicable information and authorized and entered into the accounting system. A copy of the completed purchase order will be sent to accounts payable and ordering department and vendor.

Orders can be placed with the vendor either by telephone, Fax, e-mail, mail or internet. When placing orders by telephone, the vendor contact and date of order should be noted and a confirming copy of the order sent to the vendor.

4.2 Items over $5,000 will require three bids.

4.3 Purchases made with grant funds will follow all FAR requirements and A 87 cost principles.

4.4 Purchasing will be responsible for following-up on shipping, delivery, expediting and partial shipments of ordered items to assist departments operational requirements. Purchasing will document on the purchase order or in the vender file follow up notes for verification, tracing or expediating orders.

5.0 RECORDKEEPING AND MATCHING

5.1 When Purchase Orders are issued, the Purchasing and Accounting copies will be placed in an Open Purchase Order File until the items are received.

5.2 Items will be received in accordance with the Tribe's procedures for Receiving . The completed vendor's invoices, packing list's and/or Receiving Report's will be forwarded to Accounts Payable.

Accounts Payable will then match the receiving paperwork and invoices to the open purchase order. The Accounting copy with the receiving paperwork will be forwarded to Accounts Payable. The Purchasing copy will be filed with the supporting documents and requisition in the vendor file. Purchasing will make adjustments to purchase orders if diferrence is $20.00 or less. If adjumstment required is more than $20.00 the program manager/director/coordinator will approve the adjustment. This approval may be be verbal or by email. If verbal the purchasing person will note who approved and date and time of such approval and send a confirming email to the approving person.

For partial shipments, a photocopy of the Purchase Order and the receiving paperwork will be forwarded to Accounts Payable. The original Purchase Order will be kept in the open file until all items are received.